NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

THESIS

PREEMPTING MASS MURDER: IMPROVING LAW ENFORCEMENT RISK ASSESSMENTS OF PERSONS WITH MENTAL ILLNESS

by

John D. Milby

March 2015

Thesis Co-Advisors: Kathleen Kiernan
Patrick Miller

Approved for public release; distribution is unlimited

THIS PAGE INTENTIONALLY LEFT BLANK

REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188

1. AGENCY USE ONLY *(Leave blank)*	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	March 2015	Master's Thesis

4. TITLE AND SUBTITLE
PREEMPTING MASS MURDER: IMPROVING LAW ENFORCEMENT RISK ASSESSMENTS OF PERSONS WITH MENTAL ILLNESS

5. FUNDING NUMBERS

6. AUTHOR(S) John D. Milby

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Naval Postgraduate School
Monterey, CA 93943-5000

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING /MONITORING AGENCY NAME(S) AND ADDRESS(ES)
N/A

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government. IRB protocol number ____N/A____.

12a. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for public release; distribution is unlimited

12b. DISTRIBUTION CODE
A

13. ABSTRACT (maximum 200 words)

Across the United States, mass murder events have been on the rise for nearly a decade. This thesis found that persons with serious mental illness perpetrated a statistically significant number of these events. Currently, law enforcement agencies are often the first—and in many communities the only resource—available to assist and assess mentally ill persons in crisis. This thesis investigated the current state of law enforcement training as it relates to assessing dangerousness and the risk for violence among persons with serious mental illness. It found that there is very little training and no risk assessment tool or guide currently available to assist law enforcement officers tasked with assessing mentally ill persons for dangerousness. Subsequently, this thesis examined alternative methods and models for assessing risk, including clinical violence risk assessments, and it conducted summary case studies. These included cases in which mentally ill persons committed acts of mass murder and cases where law enforcement successfully intervened and prevented mentally ill persons from carrying out planned violence. As a result of this research and analysis, a field risk assessment guide has been developed and recommended for adoption to aid law enforcement officers in assessing the dangerousness of mentally ill persons.

14. SUBJECT TERMS mental illness, serious mental illness, violence, dangerousness, involuntary civil commitment, law enforcement, mass murder, risk assessment, clinical violence risk assessment, behavioral threat assessment, active shooter, crisis intervention teams, field risk assessment tool, Washington Navy Yard, Isla Vista, DeAnza College

15. NUMBER OF PAGES
137

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
Unclassified	Unclassified	Unclassified	UU

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. 239-18

THIS PAGE INTENTIONALLY LEFT BLANK

Approved for public release; distribution is unlimited

PREEMPTING MASS MURDER: IMPROVING LAW ENFORCEMENT RISK ASSESSMENTS OF PERSONS WITH MENTAL ILLNESS

John D. Milby
Captain, Douglas County Sheriff's Office, Minden, Nevada
B.A., American Public University, 2012

Submitted in partial fulfillment of the
requirements for the degree of

**MASTER OF ARTS IN SECURITY STUDIES
(HOMELAND SECURITY AND DEFENSE)**

from the

**NAVAL POSTGRADUATE SCHOOL
March 2015**

Author: John D. Milby

Approved by: Kathleen Kiernan
Thesis Co-Advisor

Patrick Miller
Thesis Co-Advisor

Mohammed Hafez
Chair, Department of National Security

THIS PAGE INTENTIONALLY LEFT BLANK

ABSTRACT

Across the United States, mass murder events have been on the rise for nearly a decade. This thesis found that persons with serious mental illness perpetrated a statistically significant number of these events. Currently, law enforcement agencies are often the first—and in many communities the only resource—available to assist and assess mentally ill persons in crisis. This thesis investigated the current state of law enforcement training as it relates to assessing dangerousness and the risk for violence among persons with serious mental illness. It found that there is very little training and no risk assessment tool or guide currently available to assist law enforcement officers tasked with assessing mentally ill persons for dangerousness. Subsequently, this thesis examined alternative methods and models for assessing risk, including clinical violence risk assessments, and it conducted summary case studies. These included cases in which mentally ill persons committed acts of mass murder and cases where law enforcement successfully intervened and prevented mentally ill persons from carrying out planned violence. As a result of this research and analysis, a field risk assessment guide has been developed and recommended for adoption to aid law enforcement officers in assessing the dangerousness of mentally ill persons.

THIS PAGE INTENTIONALLY LEFT BLANK

TABLE OF CONTENTS

LIST OF FIGURES

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF TABLES

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF ACRONYMS AND ABBREVIATIONS

ACE	adverse childhood experience
BTA	behavioral threat assessment
CIT	crisis intervention team
DASA	dynamic appraisal of situational aggression
FBI	Federal Bureau of Investigation
FRAG	field risk assessment guide
FTO	field training officer
HCR-20	historical, clinical, risk management-20
IHOP	International House of Pancakes
LEA	law enforcement agency
LEO	law enforcement officer
SMI	serious mental illness
VRAG	violence risk appraisal guide
VRAS	Violence Risk Assessment Study
WNY	Washington Navy Yard

THIS PAGE INTENTIONALLY LEFT BLANK

EXECUTIVE SUMMARY

Law enforcement officers are regularly called upon to respond to assist mentally ill persons in crisis; some experts estimate that as many as 20 percent of all law enforcement calls for service involve persons with a mental illness.[1] In the majority of communities across the country, law enforcement is the first and often the sole community resource that can be called upon to respond and address mentally ill persons in various stages of crisis.[2] A growing body of evidence now suggests that a subgroup of persons with serious mental illness—those who are psychotic, not taking their medications, or are self-medicating through substance abuse—are significantly more dangerous than a person in the general population.[3] This places a significant public safety obligation upon law enforcement officers, as well as the duty to ensure that the mentally ill persons receive proper care and treatment for their condition.

Historically, the rationale for law enforcement intervention in non-criminal situations involving mentally ill persons is derived from two common-law principles: 1) the power and authority of police to protect the safety and welfare of the community, and 2) the state's parens patriae duty to act on the behalf of citizens who are temporarily or permanently incapable of caring for themselves.[4]

Recently, mass murders perpetrated by persons suffering from serious mental illness (SMI), including the Washington Navy Yard shooting and the Isla Vista, California shooting, have resulted in increased scrutiny of law enforcement's role in managing mentally ill persons and also sparked a national dialogue about what can be done to prevent future incidence of violence by persons with a SMI. While mental disorders are generally widespread, with nearly one in four Americans affected, about six

[1] Kevin Johnson, "Mental Illness Cases Swamp Criminal Justice System," *USA Today*, July 21, 2014, accessed September 1, 2014, http://www.usatoday.com/longform/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/

[2] Richard Lamb, Linda E. Weinberger, and Walter J. DeCuir, Jr., "The Police and Mental Health," *Psychiatric Services* 53, no. 10 (2002): 1266–1271, accessed August 17, 2014, http://psychiatryonline.org/doi/abs/10.1176/appi.ps.53.10.1266

[3] Ibid.

[4] Ibid.

percent of the population (or approximately 19 million people in the United States)[5] are believed to suffer from a serious mental illness.[6] Closer analysis of the mass murders committed from January 2013 through December 2013 reveals that while are a variety of motives for mass murder, at least half of all identified perpetrators of mass murder studied in this thesis suffered from serious mental illness or were suspected by those closest to them of having serious mental disorder.

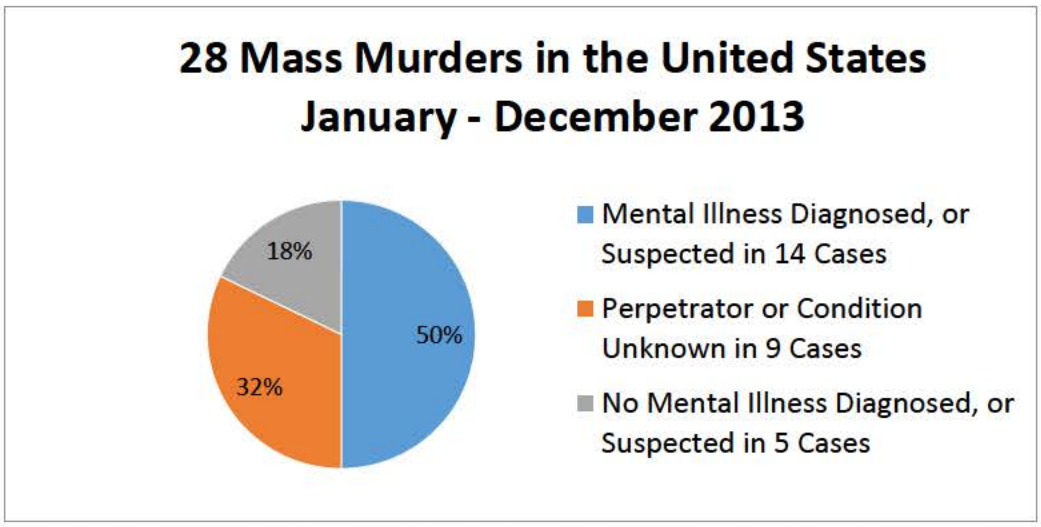

Figure 1. Prevalence of Mental Illness among Mass Murderers, 2013

According to the FBI, the incidence mass shootings and mass murder are on the rise nationally, now averaging roughly 16 a year, up from an average of six per year only a decade ago.[7] This places a significant responsibility upon law enforcement officers

[5] Serious mental illness (SMI) is defined as (1) all cases of schizophrenia; (2) severe cases of major depression and bipolar disorder; (3) severe cases of panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder; (4) severe cases of attention deficit/hyperactivity disorder; and (5) severe cases of anorexia nervosa. Timothy A. Kelly, "A Policymaker's Guide to Mental Illness," The Heritage Foundation, March 7, 2002, accessed March 13, 2013, http://www.heritage.org/research/reports/2002/03/bg1522es-a-policymakers-guide-to-mental-illness

[6] Ronald Kessler, Wai Tat Chiu, Olga Demler, and Ellen E. Walters, "Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62, no. 6 (2005): 617–627.

[7] Delvin Barrett, "Mass Shootings on the Rise, FBI Says," *The Wall Street Journal*, September 24, 2014, accessed September 25, 2014, http://www.wsj.com/articles/mass-shootings-on-the-rise-fbi-says-1411574475

who, due to their frequent interaction with mentally ill persons, must be adequately trained and equipped to assess the potential dangerousness of this growing population.

Currently, law enforcement training regarding managing mentally ill persons is limited. According to a study of 70 participating law enforcement agencies conducted in 2003, the median number of training hours for new recruits was 6.5, while the median for in-service training was a paltry one-hour of training.[8] Worse, there is no law enforcement training specific to conducting risk assessments of mentally ill persons for dangerousness, in spite of this being a routine function of law enforcement when called to assist a mentally ill person in crisis. As a result, most law enforcement assessments for dangerousness are conducted in a parochial, dichotomous manner—either there is a risk, or there is not.

Where law enforcement has made progress is in the realm of behavioral threat assessments (BTAs). This is based on the work of Robert A. Fein, a clinical psychologist with the U.S. Secret Service, and Bryan Vossekuil, a special agent with the Secret Service, who conducted the Exceptional Case Study Project in the 1990s.[9] This research employed an incident focused, behavior-based approach to analyzing 83 persons known to have engaged in 73 incidents of assassination, near assassination, or attack on public officials from 1949 to 1995.[10] This research has since been applied to the problem of identifying potential school shooters with some success, and it is informative in approaching the issue of violence among the mentally ill. But BTAs differ from the violence risk assessment law enforcement is expected to conduct when dealing with a mentally ill person in crisis in regards to the goals, context, process, structure, and, most importantly, time line.[11]

---

[8] Judy Hails, and Randy Borum, "Police Training and Specialized Approaches to Respond to People with Mental Illnesses," *Crime and Delinquency* 49, no. 1 (January 2003): 52–61.

[9] Robert A. Fein, and Bryan Vossekuil, "Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials," U.S. Department of Justice, 1998, accessed June 23, 2013, http://www.secretservice.gov/ntac/PI_Guide.pdf

[10] "National Threat Assessment Center," U.S. Secret Service, accessed October 2, 2014, http://www.secretservice.gov/ntac.shtml

[11] Ibid., 13.

While law enforcement is deficient in tools and training for assessing the dangerousness or risk for violence among mentally ill persons, researchers, clinicians, and experts in the field of mental illness are not. Researchers and clinicians have established rich theoretical frameworks and benefit from decades of significant research and experience in violence risk assessments of mentally ill persons. Subsequently, clinicians have developed several validated tools for assessing the risk for violence among the mentally ill, including Hare's psychopathy checklist, the historical, clinical risk management-20 (HCR-20), the *Violence Risk Appraisal Guide* (VRAG), and the vaunted *McArthur Violence Risk Assessment Study* (VRAS). Most importantly, as a result of this research and experience, clinicians abandoned the dichotomous "yes/no" approach to dangerousness, and instead view dangerousness as existing on a continuum.

Furthermore, though clinical violence risk assessment is still an evolving field of study, what has been conclusively established is that: 1) violence does occur with some degree of frequency among persons with mental illness; 2) that persons with certain mental disorders and symptom clusters are more likely to engage in violent behavior than persons without such; and 3) mental health professionals have some success in assessing the risk for violence among persons with mental disorder.[12]

Given this growing public safety problem, this research explores the current state of law enforcement training regarding the assessment of persons with mental illness, and asks whether law enforcement could adapt and apply proven clinical methods for gauging the risk for violence. This research also applied Professor Erik J. Dahl's *Theory of Preventive Action*, which postulates that there are two key factors necessary to prevent an attack. First, there must be precise warning with a near tactical level of specificity, and, second, there must be a high degree of receptivity with regard to the warning signs by those in a position to act.[13] Furthermore, Dahl suggests that the best way to analyze failures to stop attacks is to compare them to successfully preempted attacks.[14]

---

[12] Randy Otto, "Assessing and Managing Violence Risk in Outpatient Settings," *Journal of Clinical Psychology* 56, no. 10 (2000): 1239–1262.

[13] Erik Dahl, *Intelligence and Surprise Attack: Failure and Success from Pearl Harbor to 9/11 and Beyond* (Washington, DC: Georgetown University Press, 2013), 2–4.

[14] Ibid., 15.

Subsequently, four sample cases were examined; two cases where attacks by mentally ill perpetrators were completed, and two where they were thwarted by law enforcement. These cases were selected because in each instance, the perpetrator had contact with law enforcement prior to violence. The purpose of considering these cases is to examine what indications of dangerousness were available at the time law enforcement officers contacted the subject and to determine if these indicators correspond with violence risk factors established by clinicians.

What this research found was that in some cases, there are sufficient risk factors and warning signs of potential violence, corresponding to clinical risk factors, that law enforcement can identify and act upon in order to pre-empt violence. This research also found that in the cases of completed attacks by mentally ill perpetrators where there were sufficient risk factors present, law enforcement officers were either unaware of the risk factors or demonstrated a low level of receptivity to those factors. Conversely, in cases of thwarted attacks, law enforcement officers demonstrated a high level of receptivity to the warning signs and risk factors presented, prompting further investigation and intervention.

Finally, this research explored cases where mentally ill persons perpetrated or planned violence, confirmed that there were sufficient warning signs that correspond to clinical risk factors for violence, and integrates these risk factors into a new law enforcement risk assessment instrument. This field risk assessment guide is not intended to limit officer discretion or dictate what action officers take. Instead, by synthesizing proven risk factors from clinical and BTA models, it provides a framework for conducting comprehensive, uniform risk assessments with the hope of preventing violence. This new instrument should serve as the template for law enforcement agencies nationally in moving towards the goal of preventing acts of violence by persons with mental illness.

THIS PAGE INTENTIONALLY LEFT BLANK

PROLOGUE

Tuesday, September 6, 2011, was an archetypal late-summer morning in the capital city of Nevada. The sun had risen into a cloudless sky and the cool morning temperature, so typical of life at altitude in the Sierra Nevada Mountains, was quickly yielding to a comfortably warm day.

At 9 a.m., life tragically changed for many in the city. Eduard Sencion, a 33-year-old man who had been previously diagnosed with paranoid schizophrenia, walked into the International House of Pancakes (IHOP) on South Carson Street with an AK-47 rifle and opened fire. After shooting randomly around the restaurant, Sencion locked in on a table of Nevada Army National Guardsmen and women eating breakfast in the far corner. In a matter of seconds, Sencion had shot all five, instantly killing one, and mortally wounding two others. Sencion then exited the restaurant, shooting a woman in the head as she tried to flee. When he was finished, Sencion had shot 10 people, four of whom died at the scene. Sencion then took his own life in the parking lot—a single gunshot to the head—before police arrived on scene.

In the weeks and months following the shooting, those closest to the case struggled to make sense of what had happened and of what they had seen. There is dissonance in seeing the dead and dying lined up on the ground in front of a neighborhood eatery. Investigators were never able to adequately explain why Sencion had "snapped" or why he had chosen the IHOP. The investigation did reveal that Sencion had long struggled with schizophrenia and often experienced command voices telling him to "do bad things" to people. Debate raged among the investigators as to whether an event of this type could be prevented; the consensus was that it could not. But there was one dissenting vote.

THIS PAGE INTENTIONALLY LEFT BLANK

ACKNOWLEDGMENTS

This thesis is dedicated to the victims of violence—the innocents who are gunned down suddenly and unexpectedly while at a restaurant, theatre, mall, or school, and to those who suffer with mental illness but are unable to obtain the care and treatment their condition requires.

I owe a debt of gratitude to my wife, Kate, without whose encouragement and support I would never have applied to the Center for Homeland Defense and Security (CHDS), nor been able to finish the program. To my children, Nathanael, Calvin, and Emma, thank you for taking up my slack at home, and for being understanding when Dad spent weeks away or Saturdays at a computer doing school work instead of spending time with you.

I want to thank Sheriff Ron Pierini and Undersheriff Paul Howell for giving me the time and support to participate in this program, and to so many of my co-workers and employees who covered for me while I was in Monterey—I really was working!

To the faculty and staff of CHDS, thank you for both the opportunity, and the challenge of a lifetime. To have been afforded the opportunity to participate in this program was a great honor. I also want to thank my thesis advisors, Dr. Kathleen Kiernan and Chief Patrick Miller for their guidance and direction, and Professor Lauren Wollman for taking an interest in this work, and for her generous commitment of time instructing me in research design and methodology.

Finally, to my classmates in Cohorts 1305/1306, I can honestly say that I have soared with eagles. I wish each of you continued success and blessings in your careers and lives. Godspeed!

THIS PAGE INTENTIONALLY LEFT BLANK

I. INTRODUCTION

> It is clear that severely mentally ill individuals are responsible, by conservative estimates, for at least 5 percent of all homicides in the United States and for up to half of all "rampage" murders. Must we wait until such violence increases before we act?[1]

A. DISCUSSION

Throughout the United States today, police regularly encounter persons with serious mental illnesses in a range of circumstances and settings—in a dangerous health crisis, an incidence of domestic violence, a narcotics related arrest, the scene of some public disturbance or a serious violent crime, in a homeless encampment, or in a hospital emergency room.[2]

Recently, several widely publicized mass murders[3] involving mentally ill perpetrators have shocked the nation, raising public awareness and concern regarding violence perpetrated by persons with mental illness. From Newtown, Connecticut, to Aurora, Colorado, to Tucson, Arizona, communities large and small struggle to make sense of the senseless. Though statistically rare, it is this very senselessness and apparent randomness that makes such attacks all the more horrific. In the wake of the devastation wrought by a handful of mass murderers, politicians, peace officers, policy makers, and mental health experts struggle to explain why these events occurred, and what, if anything, can be done to prevent the next one.

In truth, the chance of being killed by a mentally ill mass murderer is, much like dying as the result of terrorism, statistically quite rare, but national media coverage and the horrific nature of these events has led to a heightened sense of crisis and increased

---

[1] E. Fuller Torrey, *The Insanity Offense: How America's Failure to Treat the Seriously Mentally Ill Endangers Its Citizens* (New York: W.W. Norton and Co., Inc., 2008), 166.

[2] Jennifer Wood et al., *Police Interventions with Persons Affected by Mental Illness* (Piscataway, NJ: Rutgers Center for Behavioral Health Services & Criminal Justice Research, 2011), 2.

[3] The Federal Bureau of Investigation defines mass murder as a number of murders, typically four or more, occurring during the same incident, with no distinctive time period between the murders. Robert J. Morton, ed., "Serial Murder: Multi-disciplinary Perspectives for Investigators," FBI Behavioral Analysis Unit 2, 2005, accessed March 12, 2013, http://www fbi.gov/stats-services/publications/serial-murder

calls for government officials to act.[4] As with terrorism, mass-mediated acts of domestic mass murder have resulted in calls for bold restrictions on civil liberties in the form of gun control, first and foremost.[5]

Nationwide, law enforcement agencies are experiencing an increase in encounters involving mentally ill persons. Some estimate that as many as 20 percent of all police calls for service involve a mentally ill person.[6] This trend is largely attributable to three factors: 1) the de-institutionalization of the mentally ill that began roughly five decades ago; 2) more recent cuts to programs designed to treat the mentally ill;[7] and 3) an influx of war veterans returning home with post-traumatic stress disorder and other psychological problems.[8] In spite of this increased interaction between law enforcement and the mentally ill, a recent study of 174 police departments serving cities of 100,000 residents or more found that more than half of these departments had no specialized response for dealing with mentally ill persons[9] and very little training.

While law enforcement agencies have responded to hundreds of active shooter events over the last several decades, the police remain largely reactive, responding to these events only after they have unfolded. Following significant criticism regarding police tactics in the wake of the 1999 Columbine High School massacre that left 15 dead and 21 injured; law enforcement agencies (LEAs) across the country began adapting their response protocols to active shooter events. Now, rather than employ the traditional tactic

---

[4] Bruce Bongar, Lisa M. Brown, Larry E. Beutler, James N. Breckenridge, and Philip G. Zimbardo, eds. *Psychology of Terrorism* (New York: Oxford University Press, 2007), 117.

[5] Ibid.

[6] Kevin Johnson, "Mental Illness Cases Swamp Criminal Justice System," *USA Today*, July 21, 2014, accessed September 1, 2014, http://www.usatoday.com/longform/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/

[7] According to the *USA Today*, states cut $5 billion and 10 percent of psychiatric beds from 2009 to 2012. Liz Szabo, "Psychiatric Bed Disappear Despite Growing Demand," *USA Today*, May 12, 2014, accessed June 17, 2014. http://www.usatoday.com/story/news/nation/2014/05/12/disappearing-hospital-beds/9003677/

[8] Cynthia Hubert, "Police Say Violent Encounters with Mentally Ill People on the Rise," *Sacramento Bee*, August 25, 2014, accessed September 1, 2014, http://www.sacbee.com/2014/08/25/6651255/police-say-violent-encounters.html

[9] Martha Williams Dean et al., "Emerging Partnerships between Mental Health and Law Enforcement," *Psychiatric Services* 50, no. 1 (January 1999): 99–101, accessed September 1, 2014, http://www.popcenter.org/problems/mental_illness/PDFs/Deane_etal_1999.pdf

of surrounding the scene and waiting for specialized units to arrive, officers have been instructed to respond rapidly, make entry without delay, and quickly locate and engage the assailant.[10] Much has been done to improve law enforcement's response to active shooter events in the 15 years following Columbine, but the fact remains that many of these events are over before the first officers arrive on scene, and the damage done in the few minutes before law enforcement officers (LEOs) have arrived is often catastrophic.[11] In light of the ineffectiveness of focusing solely on the response to such crimes, more must be done to prevent them from occurring in the first place.

This thesis does not seek to explain *why* some mentally ill subjects commit acts of mass murder; rather, this research will explore the current law enforcement approach to assessing the risk for violence among the mentally ill, determine if it is effective, and what, if anything, can be done to improve it. Responding to mentally ill persons in crisis, who may not have committed a crime, is a relatively new role for law enforcement. Traditionally tasked with responding to crimes after they have occurred, now more and more law enforcement officers are being called upon to assist with mentally ill persons in crisis, a core component of which involves assessing dangerousness and the risk for violence.[12]

As they did in the days leading up to the Washington Navy Yard (WNY) shooting, when two different LEAs contacted a distraught and paranoid Aaron Alexis, the eventual WNY shooter, police officers regularly come in contact with mentally ill subjects in various stages of crisis, and serve as the nation's front line responders in mental health emergencies.[13] This reliance on law enforcement has been made more acute by the widespread deinstitutionalization of persons suffering from serious mental

---

[10] Police Executive Research Forum, *The Police Response to Active Shooter Incidents*, March 2014, http://www.policeforum.org/assets/docs/Critical_Issues_Series/the%20police%20response%20to%20active%20shooter%20incidents%202014.pdf

[11] Ibid.

[12] Randy Borum, Robert Fien, Bryan Vossekuil, and John Berglund, "Threat Assessment: Defining an Approach for Evaluating Risk of Targeted Violence," *Behavioral Sciences and the Law* 17, no. 3 (1999): 323–337.

[13] Henry J. Steadman et al., "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," *Psychiatric Services* 51, no. 5, (2000): 645–649.

illness and subsequent lack of adequate treatment facilities and inpatient bed space. While statistically few of these subjects will commit acts of violence, let alone mass murder, given the catastrophic nature of these events, law enforcement personnel must be better equipped to assess dangerousness and the potential risk for such extreme violence.

Saying that we cannot know is not enough.

B. PROBLEM STATEMENT

Many communities across the country have been rocked by horrific mass murders, many of which involve mentally ill assailants. Law enforcement officers are the first, and in many cases the only community resource available to respond to mentally ill persons in crisis, to provide a type of triage service to the mentally ill, and to assess their needs, and the risk they might pose to themselves and the community.[14] Too often, this is assessment is done with little to no training.

While the incidence of single death homicides have been on the decline nationally for several decades now, mass murders are on the rise.[15] Though not simply a twenty-first century phenomenon, mass murders, active shooter events, and the number of casualties from these incidents have been rising steadily over the past decade.[16]

Some work has been done to prevent violence, with the Secret Service and Federal Bureau of Investigations (FBI) leading the way in research on behavioral threat analysis. This research, known as behavioral threat assessment (BTA), has focused primarily on assassins and school shooters. Current BTA is predicated on the notion that these attackers "consider, plan, and prepare,"[17] resulting in detectable behavior that can

---

[14] Peter C. Patch, and Bruce A. Arrigo, "Police Officer Attitudes and Use of Discretion in Situations Involving the Mentally Ill," *International Journal of Law and Psychiatry* 22, no. 1 (1999): 23–35.

[15] Dale Archer, "Mass Murders are on the Rise: Single Death Homicides are Down While Mass Murders Are Up. Why?" *Psychology Today*, July 28, 2012, accessed March 17, 2014, http://www.psychologytoday.com/blog/reading-between-the-headlines/201207/mass-murders-are-the-rise

[16] J. Pete Blair, M. Hunter Martaindale, and Terry Nichols, "Active Shooter Events from 2000 to 2012," *FBI Law Enforcement Bulletin*, January 2014, http://leb.fbi.gov/2014/january/active-shooter-events-from-2000-to-2012

[17] Andre Simons, *FBI Behavioral Analysis Unit* (Quantico, VA: National Center for the Analysis of Violent Crime, 2012), accessed April 5, 2014, http://www.dbhds.virginia.gov/documents/130124Simons.pdf

provide opportunities for detection and disruption. But this model may not apply to mentally ill assailants, who often seem to attack spontaneously, without motive, rationale, or planning.

Prevention efforts have also focused on hardening facilities such as school campuses, government offices, and the like. These efforts to harden facilities often focus on denying access to assailants, improving employee response to such incidents, and occasionally include armed or unarmed security personnel. These efforts are clearly an important component to violence prevention and mitigation, but they are only part of the equation, and ultimately these efforts are unlikely to stop determined assailants like those who successfully attacked the Washington Navy Yard and Fort Hood on two separate occasions.

While the incidence of violence among the mentally ill, particularly those suffering from schizophrenia[18] or mental illness with co-occurring substance abuse[19] is statistically significant, very few persons suffering from mental illness will commit murder, let alone mass murder. However, in spite of the statistics, there appears to be a troubling trend nationally: persons suffering from mental illness perpetrating horrific acts of mass murder, and this happens despite contact with law enforcement, mental health professionals, and others who were, or should have been aware of some level of dangerousness and risk.

There have been more than 200 mass murder events in the United States since 2006, which equates to a mass murder somewhere in the United States about once every two weeks.[20] Closer analysis of the mass murders committed from January 2013 through December 2013, reveals that while there exists a variety of motives for mass murder, at

---

[18] Patricia A. Brennan, Sarnoff A. Mednick, and Sheilagh Hodgins, "Major Mental Disorders and Criminal Violence in a Danish Birth Cohort," *Archives of General Psychiatry* 57, no. 5 (May 2000): 494–500.

[19] Jill RachBeisel, Jack Scott, and Lisa Dixon, "Co-Occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research," *Psychiatric Services* 50, no. 11 (1999), 1427–1434, accessed August 25, 2014, http://journals.psychiatryonline.org/article.aspx?articleid=83559#Conclusions

[20] Jodi Upton, Paul Overberg, and Meghan Hoyer, "Behind the Bloodshed: The Untold Story of America's Mass Killings," *USA Today*, December 4, 2013, accessed December 6, 2013, http://usatoday30.usatoday.com/news/nation/mass-killings/index.html#explore

least half of all identified perpetrators of mass murder suffered from serious mental illness or were suspected of having a serious mental disorder by friends and family. Figure 1 examines the 28 mass murder events resulting in 128 victims in 2013. Exactly half of the perpetrators were known to have or suspected of having a serious mental illness, nine are unknown, and only five were known to not suffer from any mental illness.

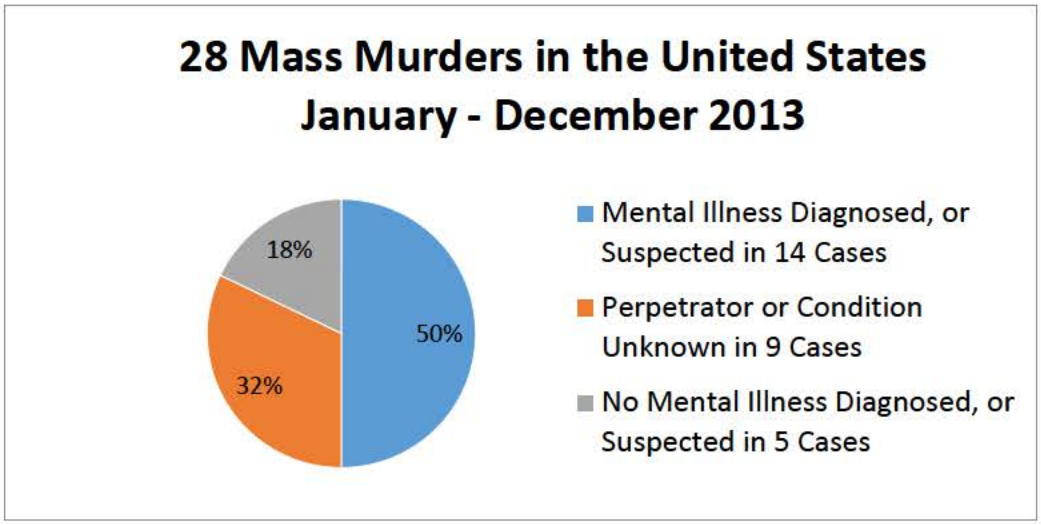

Figure 1. Prevalence of Mental Illness Among Mass Murderers, 2013[21]

These figures are startling and help explain the growing public concern regarding the apparent correlation between mental illness and violence. Subsequently, LEOs and other first responders who are regularly called upon to respond and assist mentally ill persons in crisis must be prepared to effectively assess mentally ill subjects for dangerousness, to conduct a comprehensive risk assessment, and take appropriate action to prevent violence.

Further complicating matters is deinstitutionalization, which has resulted in a shortage of beds in the few remaining inpatient treatment facilities. By some estimates, jails and prisons now house more than 356,000 persons with mental illness, compared to

[21] See appendix A for detailed information regarding 2013 mass murders.

just 35,000 in state hospitals.[22] Jails in particular have become a revolving door for mentally ill subjects in crisis, defacto mental institutions,[23] but incarceration is a costly and short-term solution with all but the most violent of offenders soon released back into the community. This makes the management of violent people suffering from mental illness a topic of major concern to clinicians and criminologists alike.[24]

Currently, clinicians and LEOs largely operate apart from each other, with clinicians bearing primary responsibility for assessing the potential future risk for violence, and law enforcement officers typically responding once someone is in crisis, or violence has occurred. As a result, clinicians have vastly improved their ability to assess the risk for violence in persons suffering from mental illness, while law enforcement officers have few tools, and little guidance regarding how to assess dangerousness, or when to act to prevent violence.

While mental disorders are relatively widespread, with nearly one in four Americans affected, only about six percent of the population are believed to suffer from a serious mental illness (SMI)[25] or approximately 19 million people across the United States.[26] It is this six percent that accounts for many of the calls for law enforcement to assist or intervene—to quickly assess the dangerousness of an individual and make a reasonable decision often without complete knowledge. LEOs, used to proving things "beyond a reasonable doubt," must become more comfortable with making such critical forecasts of dangerousness realizing that, as Kenneth Arrow has stated, "most individuals

---

[22] Jenny Gold, "The Mentally Ill Mostly Go to Jail, Not Psych Hospitals: American Jails House 10 Times More Mentally Ill People than State Hospitals," *Kaiser Health News*, April 9, 2014, accessed April 11, 2014, http://www.governing.com/news/headlines/the-mentally-ill-mostly-go-to-jail-not- html

[23] Torrey, *The Insanity Offense*, 129.

[24] Eric Silver, "Understanding the Relationship between Mental Disorder and Violence: The Need for a Criminological Perspective," *Law and Human Behavior* 30, no. 6 (2006): 685–706.

[25] Serious mental illness (SMI) is defined as (1) all cases of schizophrenia; (2) severe cases of major depression and bipolar disorder; (3) severe cases of panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder; (4) severe cases of attention deficit/hyperactivity disorder; and (5) severe cases of anorexia nervosa. Timothy A. Kelly, "A Policymaker's Guide to Mental Illness," The Heritage Foundation, March 7, 2002, accessed March 13, 2013, http://www.heritage.org/research/reports/2002/03/bg1522es-a-policymakers-guide-to-mental-illness

[26] Ronald Kessler, Chiu, Wai Tat, Demler, Olga, and Ellen E. Walters, "Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62, no. 6 (2005): 617–627.

underestimate the uncertainty of the world…our knowledge of the way things work, in society or in nature, comes trailing clouds of vagueness."[27]

Law enforcement training on interacting with mentally ill persons has evolved and improved dramatically over the past several decades. Considered by many to be a law enforcement "best practice," crisis intervention teams (CIT) consisting of officers specially trained to respond to mentally ill persons in crisis are popping up in agencies of all sizes across the country.[28,] CIT, also known as the Memphis model for the city where it was first developed and instituted, focuses almost exclusively on de-escalating situations involving mentally ill persons.[29] While de-escalation is crucial, training for assessing dangerousness and the risk for violence posed by a mentally ill person is conspicuously absent from the CIT curriculum.

The *Merriam-Webster Dictionary* defines "risk" as "the possibility of loss or injury: peril."[30] Moreover, risk analysis involves considering the following three questions: 1) what can happen? 2) how likely is it that it will happen?, and 3) if it does happen, how bad will it be?[31] A risk assessment, then, for the purposes of this research is defined as a prediction of risk resulting from a systematic evaluation of facts and circumstances obtained in the course of an investigation.[32] Considering the tragic outcomes in many well publicized cases involving violent mentally ill persons, it is

---

[27] Michael Szenberg, *Eminent Economists: Their Life Philosophies* (New York: Cambridge University Press, 1992).

[28] Johnny K. Jines, "Crisis Intervention Teams: Responding to Mental Illness Crisis Calls," *FBI Law Enforcement Bulletin*, January 2013, http://leb fbi.gov/2013/january/crisis-intervention-teams-responding-to-mental-illness-crisis-calls;

Kevin Johnson, "Memphis Program Offers Example for Police and Mentally Ill," *USA Today*, October 2, 2013, http://www.usatoday.com/story/news/nation/2013/10/02/police-navy-yard-mental-illness-alexis-shooting/2910763/

[29] Randolph DuPont et al., *Crisis Intervention Team Core Elements* (Memphis, TN: University of Memphis School of Urban Affairs and Public Policy, 2007), http://cit memphis.edu/information_files/CIT_Brief_Overview_Presentation_Slides.pdf

[30] *Merriam-Webster*, s.v., "risk," accessed March 14, 2014, http://www merriam-webster.com/dictionary/risk

[31] Stanley Kaplan, and B. John Garrick, "On the Quantitative Definition of Risk," *Risk Analysis* 1, no. 1 (1981): 11–27.

[32] Wayne Petherick, *Applied Crime Analysis: A Social Science Approach to Understanding Crime, Criminals, and Victims* (Waltham, MA: Anderson Publishing 2015), 173.

important to evaluate how well law enforcement is doing in assessing dangerousness and managing persons suffering from mental illness.

A review of the literature has revealed that while there are numerous violence risk assessment tools available to clinicians, there is little to assist law enforcement or other first responders with assessing the potential risk for violence when dealing with mentally ill persons. This thesis seeks to examine the problem of violence, extreme violence, and mass murder in particular, perpetrated by persons with serious mental illness. Through the research, the intent is to identify strategies to better equip LEOs and other first responders to assess the risk for violence among the mentally ill.

> The essence of risk management lies in maximizing the areas where we have some control over the outcome while minimizing the areas where we have absolutely no control over the outcome and the linkage between effect and cause is hidden from us…Further, when information is incomplete, as it almost always is, we must apply inductive reasoning to assess the risk of something happening.[33]

C. RESEARCH QUESTIONS

The primary question this research seeks to address is: *Can law enforcement preempt mass murder and other violent events perpetrated by persons with serious mental illness by employing clinical violence risk assessment techniques?* To answer this question, this research will assess current law enforcement practices and both clinical risk assessment and behavioral threat assessment models for assessing the risk for violence. The research will also examine episodes of violence perpetrated by persons suffering from mental illness, as well as some successfully thwarted cases in which mentally ill persons had planned a violent attack but had been stopped by law enforcement intervention.

A secondary question this research will consider is: *Can clinical violence risk assessment instruments and the behavioral threat assessment model be synthesized into a guide for field use by law enforcement officers in order to aid assessing the risk for violence among persons suffering from mental illness?* To answer this question, the

[33] Peter L. Bernstein, *Against the Gods: The Remarkable Story of Risk* (New York: Wiley and Sons, 1996), 197–202.

research will explore both clinical risk assessment and behavioral threat assessment approaches to violence risk assessment and the feasibility of synthesizing components from each in order to develop a comprehensive model that has practical application for law enforcement officers in the field.

D. SIGNIFICANCE TO THE FIELD

In 2011, New Windsor, New York Police Chief Michael C. Biasotti conducted groundbreaking research into the impact of mental illness on law enforcement resources by conducting a survey of over 2,000 law enforcement executives while studying at the Naval Postgraduate School's Center for Homeland Defense and Security. Chief Biasotti demonstrated how the de-institutionalization of persons with serious mental illness has resulted in an exponential increase in law enforcement interaction with the mentally ill, drawing limited law enforcement resources away from both the traditional mission of crime-fighting, and its new role in homeland security.[34] This research seeks to pick up where Chief Biasotti's research left off by examining one of law enforcement's primary roles in interacting with mentally ill persons in crisis: assessing dangerousness and the risk for violence.

Though they are called upon regularly to assist mentally ill persons in crisis and assess their risk for violence, an examination of current best practices reveals that law enforcement officers are often ill equipped to conduct objective risk assessments of persons with mental illness. The purpose of this study is to prevent future violence by providing law enforcement personnel a tool for conducting more comprehensive violence risk assessments by synthesizing elements of the latest techniques in both clinical risk assessment and behavioral threat assessment research. By conducting a more accurate violence risk assessment, this thesis hypothesized that that law enforcement officers may increase the likelihood of treatment and reduce incidence of violence perpetrated by persons with mental illness.

[34] Michael C. Biasotti, "Management of the Severely Mentally Ill and its Effects on Homeland Security" (master's thesis, Naval Postgraduate School, 2011), 84–86.

E. THESIS OUTLINE AND UPCOMING CHAPTERS

Chapter II contains a review of pertinent literature that addresses several facets of the problem. It looks at the correlation between mental illness and violence, mass murder and active shooter events. In addition, the chapter includes an examination of existing law enforcement approaches to mental illness and risk assessments and clinical approaches to violence risk assessments, as well as sample case studies.

Chapter III explains the research design, which is the application of clinical and BTA risk factors to select cases. Chapter IV then examines traditional law enforcement approaches to mental illness, including training and current threat assessment models. Chapter V contains four summary case studies for analysis. Two cases are of attacks perpetrated by mentally ill persons following contact with law enforcement, and two are of attacks planned by mentally ill persons but were thwarted following contact with law enforcement. Chapter VI examines a variety of common clinical tools for conducting violence risk assessments. Chapter VII identifies key clinical and BTA risk factors, and reconsiders the summary cases in light of these risk factors. Finally, Chapter VIII summarizes the research and proposes a new risk assessment guide for law enforcement officers tasked with assessing dangerousness among persons with mental illness.

THIS PAGE INTENTIONALLY LEFT BLANK

II. LITERATURE REVIEW

> In this zeal for liberty, many hundreds of sick persons are annually deprived of the liberty of obtaining the medical treatment they require, obtaining in exchange only the liberty to commit suicide or homicide.[35]

A. INTRODUCTION

The mentally ill mass murderer is not a new phenomenon, but it is an important public safety issue that has come to the forefront of public discourse in the United States following the horrific shootings in Newtown, Aurora, Tucson, Washington D.C., and elsewhere. This thesis asks the question of whether or not law enforcement can help prevent violence and preempt mass murderer by conducting a more comprehensive violence risk assessment during contact with mentally ill persons in the field.

This literature review is intended to examine the body of research, writing, and thought relating to the issues of mass murder, violence among the mentally ill, the behavioral threat assessment model, and other law enforcement approaches to assessing the risk for violence. It will also include a sampling of incidence of mass murder intended to identify missed warning signs and specific, tactical level intelligence that law enforcement could use to prevent an act of violence, perhaps even mass murder perpetrated by a person suffering from mental illness.

To achieve this goal, it was necessary to examine and synthesize data from a broad range of publications and resources from several distinct disciplines and areas of research, as well as a sampling of mass murder events. Subsequently, this literature review is divided into the following six categories:

1. Mental illness and violence
2. Mass murder and active shooter events
3. Clinical approaches to assessing the risk for violence
4. Existing law enforcement approaches to risk assessment

[35] "Lunatics at Large and the Public Press," *Journal of Mental Science* 44 (January 1898): 110, http://bjp rcpsych.org/content/44/184/110

5. Criminological approaches to mental health issues
6. Summary case studies

B. MENTAL ILLNESS AND VIOLENCE

There is a significant amount of literature, research reports, and journals regarding the topic of mental illness and violence. Much of the literature examined for this project can be divided into three main categories: 1) studies that examine whether or not there is a causal relationship between mental illness and violence and what co-occurring factors may influence this phenomenon, 2) studies that examine the influence criminological and demographic factors have on the mentally ill and the likelihood for violence, and 3) research intended to assist clinicians in predicting the likelihood of violence among the mentally ill.

When approaching the topic of mental illness and violence, it is common for many to assume a causal relationship between mental illness and violence. While the public may intuitively sense that the mentally ill are more violent than non-mentally ill persons, the research on this is somewhat divided. Some early studies suggested that mental illness was not associated with an increased likelihood for violence, however a preponderance of recent studies indicate that the likelihood of committing violence is in fact greater for people with serious mental illness than it is for those without.[36] Table 1 lists some of the studies linking mental illness with an increased risk for violence.

[36] Silver, "Understanding the Relationship between Mental Disorder and Violence."

Table 1. Selected Studies Supporting Link between Mental Illness and Violence[37]

Study	Major Findings
Swanson et al. (1990)	Major mental disorders creates 5_ risk of violence
Link et al. (1992)	Patient groups 2–3_ more violent than nonpatient groups (when symptomatic); psychotic symptoms predict violence, even in nonpatient groups
Hodgins (1992)	Sweden birth cohort study: odds ratio (OR) = 4 for major mental disorder and violence
Link and Stueve (1994)	Violence predicted by three specific psychotic symptoms: threat, control, and override
Swanson et al. (1996)	Replicates Link and Stueve (1994) using Epidemiological Catchment area study data
Link et al. (1998)	Threat and control/override symptoms independently predict violence
Tiihonen, Isohanni, Rasanen, Kioranen and Moring (1997)	Finland birth cohort: OR = 7 for male schizophrenia and violence
Hoptman et al. (1999)	Dual diagnosis of schizophrenia and SA and thought disorder correlated with violence
Swanson et al. (2000)	Paranoid and threat/control-override (TCO) symptoms significantly associated with risk of violence
McNeil et al. (2000)	Among civil inpatients, command hallucinations created 2.5_increase in violence
Brennan, Mednick, & Hodgins (2000)	Denmark birth cohort: OR = 4.6 for male schizophrenia and violence, 23 for female schizophrenia and violence
Arsenault, Moffitt, Caspi, Taylor, and Silva (2000)	New Zealand birth cohort: alcohol dependence (OR = 1.9), marijuana dependence (OR = 3.8), and schizophrenia – spectrum disorders (OR = 2.5) each strongly related to violence
Gray et al. (2003)	Brief Psychiatric Rating Scale score significantly correlated with inpatient violence
Wallace, Mullen, and Burgess (2004)	Australia birth cohort: Schizophrenia OR = 3.6–6.6 for various cohorts over 25-year period
Beck (2004)	Delusions present in half of cases of serious violence, most of TC type; but delusional violence uncommon in absence of SA history
Swanson et al. (2006)	Serious violence risk associated with higher positive symptom score and lower negative symptom score (on Positive and Negative Syndrome Scale)
Teasdale et al. (2006)	For males, threat delusions increase risk of violence

There has been a tremendous amount of research done among clinicians regarding mental illness and violence. As a result of the deinstitutionalization of the severely mentally ill, which began following the Second World War, the question of how to manage the mentally ill and assess the risk they pose to the public has become an increasingly important one.[38] Clinicians play a primary role in the assessment of the threat posed by mentally ill persons in order to determine if they should be released from

[37] Michael A. Norko, and Madelon V. Baranoski, "The Prediction of Violence; Detection of Dangerousness," *Brief Treatment and Crisis Intervention* 8, no. 1 (February 2008): 73–91.

[38] Torrey, *The Insanity Offense,* 1–2.

jail, or hospitalized involuntarily, to distinguish, in essence, with as much certainty as possible, between the dangerous and non-dangerous.[39] To this end, numerous risk assessment tools and actuaries have been devised to assist clinicians in making such predictions. Recent studies point to success in predicting violence among the mentally ill when a broad range of factors in addition to psychopathy are examined. These added factors include age, gender, substance abuse, criminal history, and prior history of violence and aggression.[40]

C. MASS MURDER AND ACTIVE SHOOTER EVENTS

Most literature relating to the criminal offense of multiple-victim homicides appears to focus on serial killers. This is due in part to the prevalence of serial killer stories in the media, print, and in entertainment.[41] What literature that can be found on the subject of mass murder is predominantly focused on school shootings, the politics surrounding gun control, and some discussion on the topic of keeping firearms from the mentally ill. This is due in large part to the appalling school shooting in Newtown, Connecticut, and the prevalence of mass murder/active shooter stories in the national media involving persons who appear to be suffering from mental illness.

Sources of literature on the subject of mass murder are found in government publications, scholarly journals, and a few books. Another useful source of information on the topic of mass murder is a comprehensive study published in 2013 by a team of researchers at *USA Today*, *Behind the Bloodshed*, which attempts to catalogue every mass murder event in the United States.

---

[39] John Monahan et al., *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence* (New York: Oxford University Press, 2001), 5.

[40] Mario Amore, Marco Menchetti, Christina Tonti, Fabiano Scarlatti, Eva Lundgren, William Esposito, and Domenico Berardi, "Predictors of Violent Behavior among Acute Psychiatric Patients: Clinical Study," *Psychiatry and Clinical Neurosciences* 62, no. 3 (June 2008): 247–255.

[41] David Schmid, *Natural Born Celebrities: Serial Killers in American Culture* (Chicago: University of Chicago Press, 2005), 3.

Some work examines the various typologies of mass murders (coinciding with efforts to profile serial killers), with at least five distinct varieties being commonly identified:[42]

1. the domestic killer
2. the pseudo-commando
3. the disgruntled or revenge killer
4. the mentally ill or psychotic killer
5. the political terrorist

While mass murder committed by a mentally ill perpetrator has been described as "statistically rare and virtually unpredictable,"[43] numerous other studies and authors refute this. In his 2006 article for the journal *Law and Human Behavior*, Dr. Eric Silver wrote:

> Although studies conducted prior to the 1980s seemed to suggest that mental disorder was not associated with violence the vast body of research conducted since that time…suggests a different conclusion. Specifically, recent work in this area indicates that although most people with major mental disorder do not engage in violence, the likelihood of committing violence is greater for people with a major mental disorder than for those without, and that substance misuse raises the risk of violence by people with mental disorder substantially.[44]

Subsequently, this research will not seek to enter into the debate over whether or not there is an increased risk for violence among persons with mental illness. Rather, this research will examine specific cases of mass murder perpetrated by persons with mental illness in order to determine if there are common clues or signals that precede an attack.

D. CLINICAL APPROACH TO ASSESSING THE RISK FOR VIOLENCE

Over the past half century, there has been extensive clinical research into predicting violence among the mentally ill, particularly persons suffering from serious mental illnesses such as bi-polar disorder, schizophrenia, and major depression. Clinical

---

[42] James A. Fox, and Jack Levin, *Extreme Killing: Understanding Serial and Mass Murder* (Los Angeles: Sage Publications, Ltd, 2012), 23.

[43] Daniel W. Webster, and Jon S. Vernick, *Reducing Gun Violence in America: Informing Public Policy with Evidence and Analysis* (Baltimore: Johns Hopkins University Press, 2013), 34.

[44] Silver, "Understanding the Relationship between Mental Disorder and Violence."

violence prediction is an inexact science. Early actuarial and assessment tools and techniques, often referred to as "first-generation" studies, often produced results that were little better than chance.[45] This body of research has grown tremendously in the past few decades, and the ability to predict violence in some persons has improved as well.

This body of research has grown exponentially during the past two decades, due in large part to significant grants from the John D. and Catharine T. MacArthur foundation, and to Dr. John Monahan and his work on the MacArthur risk study. The MacArthur risk study was groundbreaking, and it began to shift the risk paradigm from a yes/no prediction to an assessment of risk based on degrees.[46] Dr. Monahan's work, including his books *The Clinical Prediction of Violent Behavior*, published in 1977,[47] and *Rethinking Risk Assessment: The MacArthur Study of mental Disorder and Violence*, published in 2001,[48] remain foundational to the field of clinical risk assessment.

Though many clinicians have concluded that untreated mental illness does create a moderate increase in the risk for violence, mental illness is not the only factor that must be considered. A multivariate approach is necessary, and the most critical factors for predicting violence are co-occurring disorders of severe mental illness and substance abuse, coupled with a history of violence.[49] Some clinicians and researchers have also begun to look at environmental and other factors that play a role in violence among all people, not just the mentally ill. A comprehensive approach to risk assessment for violence is critical to producing the most accurate assessment possible.

---

[45] Mairead Dolan, and Michael Doyle, "Violence Risk Prediction: Clinical and Actuarial Measures and the Role of the Psychopathy Checklist," *British Journal of Psychiatry* 177 (2000): 303–311.

[46] Mary Alice Conroy, and Daniel C. Murrie, *Forensic Assessment of Violence Risk: A Guide for Risk Assessment and Risk Management* (Hoboken, NJ: John Wiley & Sons, Inc., 2007), 7.

[47] John Monahan, *Clinical Prediction of Violent Behavior* (New York, NY: Jason Aronson, Inc., 1977).

[48] John Monahan, Henry J. Steadman, Eric Silver, Paul S. Appelbaum, Pamela Clark Robbins, Edward P. Mulvey, Loren H. Roth, Thomas Grisso, and Steven Banks, *Rethinking Risk Assessment: The MacArthur Study of mental Disorder and Violence* (New York, NY: Oxford University Press, 2001).

[49] Eric B. Elbogen, and Sally C. Johnson, "The Intricate Link between Violence and Mental Disorder," *Archives of General Psychology* 66, no. 2 (2009): 152–161.

E. LAW ENFORCEMENT APPROACH TO BEHAVIOR THREAT ASSESSMENT

While clinicians have been researching the risk for violence among the mentally ill for decades, law enforcement agencies such as the United States Secret Service and the Federal Bureau of Investigation's Behavioral Analysis Unit have also examined the problem.[50] The Secret Service is a leader in this field; it has conducted two of the most comprehensive studies of pre-attack behavior under the guidance of forensic psychologist Robert Fein, PhD.[51]

These studies found that most attackers typically engage in similar pre-attack planning, which can last for days or even months.[52] Additionally, while the Secret Service literature asserts that there is no such thing as an attacker or assassin demographic profile, many attackers did share common characteristics. Interestingly, these characteristics, among others, include a history of social isolation, weapons use (though rarely a criminal history), explosive, angry behavior, serious depression or despair, and suicidal ideations.[53]

While work done by the U.S. Secret Service is extremely useful to law enforcement, schools, and others, its research focused solely on 83 persons who, from 1949 to 1996 attacked, or planned to attack public officials. Secret Service studies found that mental illness rarely played a key role in assassination behavior, and that assassination-type attacks, almost without exception, involved organized thinking and

[50] Work done by the FBI's Behavior Analysis Unit focuses primarily on school and workplace shooters, and it relies heavily on the research done by Robert Fein and Bryan Vossekuil for the U.S Secret Service.

[51] Anna Miller, "Threat Assessment in Action," *Monitor on Psychology* 45, no. (2014): 37.

[52] Robert A. Fein, and Bryan Vossekuil, *Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials* (Washington, DC: US Department of Justice, 1998); Bryan Vossekuil et al., *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States* (Washington, DC: The United States Secret Service and the United States Department of Education, 2002).

[53] Robert A. Fein, and Bryan Vossekuil, *Protective Intelligence & Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials* (Washington, DC: U.S. Department of Justice, 1998), 12–13.

behavior prior to the attack.[54] Subsequently, this research may not have direct application to the problem of the mentally ill mass murderer.

F. CRIMINOLOGICAL APPROACH TO MENTAL HEALTH ISSUES

The deinstitutionalization of persons suffering from severe mental illness has had a significant impact on law enforcement organizations across the country. Deinstitutionalization first resulted in an exponential increase in police contacts with mentally ill persons[55] and frequent incarceration of persons with mental illness[56]. As a result, law enforcement agencies have struggled for decades to deal with the increasing numbers of mentally ill subjects found on the streets and in the neighborhoods and jails of every American city.

In examining the literature, it becomes apparent that there are significant policy challenges facing law enforcement agencies as peace officers are the primary mental health care responders; yet, they are largely unprepared to deal with mentally ill people in crisis. This inadequacy to the task is primarily manifested in two ways: police reliance on violence when dealing with the mentally ill, and the high rates of incarceration of mentally ill persons, often referred to as "criminalization."

When called to deal with a non-criminal event in which a subject is exhibiting symptoms of mental illness, law enforcement officers operate under *parens patriae*, or the concept that the state has an obligation to care for citizens who are unable to care for themselves.[57] In most states, this results in an officer making a determination as to whether or not the subject poses an imminent threat of danger to themselves or others.

In recent years, an apparent increase in fatal encounters between law enforcement and persons suffering from mental illness have some law enforcement leaders and other

---

[54] Ibid., 13–16.

[55] J. C. Bonovitz, and J. S. Bonovitz, "Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective," *American Journal of Psychiatry* 138, no. 7 (1981): 973–976.

[56] Linda A. Teplin, Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill, *American Psychologist* 39, no. 7 (1984): 794–803. For more information on this topic, please refer to the NPS thesis completed by Chief Michael Biasotti.

[57] Conroy, and Murrie, *Forensic Assessment of Violence Risk*.

experts questioning whether law enforcement organizations are properly trained and equipped to deal with the problem effectively.[58] Simultaneously, while police encounters with the mentally ill have increased, so have public expectations that peace officers be trained and equipped to deal with mentally ill persons in a humane and compassionate way. Crisis intervention teams (CIT), an approach to effectively handling the mentally ill created by the Memphis Police Department in the wake of a violent encounter with a mentally ill person, is one of the most successful and well-known efforts at training peace officers to better handle persons in crisis.[59]

What is apparent from the literature in this field of study is that while there is an increased awareness of the challenges posed by the deinstitutionalization of persons with SMI, there remains a lack of research and resources aimed at equipping peace officers to assess the potential for violence among the mentally ill persons they encounter. Now, with a seemingly growing number of mentally ill persons committing widely publicized acts of mass murder, there appears to be a growing expectation that peace officers also improve in this fundamental public safety role as well.

G. SUMMARY CASE STUDIES

This research includes summary case studies of both completed mass murder events, and mass murders that were preempted by LEOs. This brief survey of several well-publicized cases will be conducted in order to analyze the presence or absence of warning signs or other indicators of dangerousness, what those indicators were, and the receptiveness of LEOs to those indicators, a research methodology first employed by Erik J. Dahl in his work on analyzing more traditional surprise attacks.[60] Since this research is not designed to examine the response to active shooter/mass murder events, but potential

[58] Gary Fields, "Lives of Mentally Ill, Police Collide: Law-enforcement Professionals and Mental-health Advocates Believe They Are Seeing an Increase in Fatal Encounters between Police and the Mentally Ill," *The Wall Street Journal*, October 22, 2013, accessed June 18, 2014, http://online.wsj.com/news/articles/SB10001424052702304561004579135623495179250

[59] Jines, "Crisis Intervention Teams: Responding to Mental Illness Crisis Calls."

[60] Erik J. Dahl, *Intelligence and Surprise Attack: Failure and Success from Pearl Harbor to 9/11 and Beyond* (Washington, DC: Georgetown University Press, 2013), 68.

precursors to violence, this research will focus on the attacker's background and their behavior antecedent to the attack.

Summary case studies are based on open-sources and public information available in police reports, newspapers, scholarly journals, and other government documents and publications. Subsequently, cases have been selected based on the availability of adequate open-source information necessary to conduct the research and analysis.

H. CONCLUSION

There is tremendous literature regarding mental illness and violence and the law enforcement response to the challenge of dealing with persons suffering from mental illness. This thesis will seek to synthesize the literature and research from each of these disciplines in order to improve law enforcement risk assessment practices, increase treatment opportunities for those suffering from mental illness, and reduce violence among this demographic.

III. RESEARCH DESIGN

> Our present policy of discharging helpless human beings to a hostile community is immoral and inhumane. It is a return to the Middle Ages, when the mentally ill roamed the streets and little boys threw rocks at them.[61]

A. INTRODUCTION

While law enforcement has greatly increased its capacity to respond to an active shooter event and its grisly aftermath, many are now understandably calling on law enforcement organizations to intercede before the perpetrator can commit an act of murder.[62] This notion of preventing an active shooter-mass murder event, whether perpetrated by a mentally ill subject or not, implies that there are adequate, discernable warning signs that can be observed and acted upon prior to the event. Unfortunately, law enforcement officers today approach their role in violence risk assessment without adequate training and often from a dichotomous "yes or no" perspective. This is not adequate, as clinicians have demonstrated that risk should be considered along a spectrum or scale from less to greater.

In examining risk and precedent factors or behaviors, traditional intelligence theory suggests that "accurate information on what is about to transpire can always be found within the intelligence pipeline;"[63] however, this conventional wisdom has recently been challenged. For example, Professor Erik J. Dahl, in his *Theory of Preventive Action*, postulates that there are two key factors necessary to prevent an attack. First, there must be precise warning with a near tactical level of specificity, and, second, there must be a high degree of receptivity with regard to the warning signs by

---

[61] Robert Reich, "Care of the Chronically Mentally Ill: A National Disgrace," *American Journal of Psychiatry* 130 (1973): 911–912.

[62] James P. Gaffney, "Can Police Prevent an Active Shooting Incident?" *Law Enforcement Today*, April 2014, accessed May 6, 2014, http://www.lawenforcementtoday.com/2014/04/19/can-police-prevent-an-active-shooting-incident/

[63] James J. Wirtz, "The American Approach to Intelligence Studies," in *Handbook of Intelligence Studies*, ed. Loch K. Johnson (London: Routlege, 2007), 51.

those in a position to act.[64] Furthermore, Dahl suggests that the best way to analyze failures in stopping attacks is by comparing them to successfully preempted attacks.[65]

In many instances of mass murder perpetrated by mentally ill persons, it is clear that there were warning signs that went unrecognized by peace officers and others who had contact with the attacker. Therefore, it is this framework of sufficient warning signs, signal receptivity, and the analysis of both failures and successes that will be used to explore specific cases of mass murder perpetrated by mentally ill persons and cases where mass murder was preempted. The purpose of this analysis is to examine the types of warning signs that existed prior to the events, as well as the level of receptivity by LEOs in a position to observe the warning signs.

A secondary framework will be applied in the examination of warning signs and antecedent factors—that of the clinical risk assessment. Additionally, this framework will seek to divide warning signs into several distinct categories—demographic risk factors, clinical risk factors, historical risk factors, and contextual risk factors. Serious mental illness has been established as a moderate risk factor for violence, but mental illness is not the only factor that increases the risk for violence. Persons tasked with assessing the risk for violence in mentally disordered subject must also consider the typical criminological and contextual variables such as age, gender, criminal history, the contemporaneous occurrence of stressful life events, social disorganization, and the lack or presence of social controls to name a few.[66]

B. ANALYSIS OF LITERATURE

This thesis seeks a synthesis of divergent areas of study to address the issue of mental illness and mass murder. Subsequently, an examination was conducted into literature on the following topics:

1. Mental illness and violence
2. Mass murder and active shooter events

---

[64] Dahl, *Intelligence and Surprise Attack*, 2–4.

[65] Ibid., 15.

[66] Silver, "Understanding the Relationship between Mental Disorder and Violence."

3. Clinical approaches to assessing the risk for violence
4. Law enforcement approaches to behavioral threat assessment
5. Criminological approaches to mental health issues
6. Sampling of both completed and thwarted mass murder events

It should be noted that while there has been extensive clinical research and much written on the correlation between mental illness and violence and the validity of clinical violence risk assessment tools, little research or writing has been done on the subject of violence risk assessment as it relates to law enforcement. The vast majority of law enforcement literature on the topic of mass murder and active shooter events focuses on response to such incidents and reveal recent calls for a focus on prevention.

C. SUMMARY CASE STUDIES

The object of this research is the phenomenon of mental illness and extreme violence in the form of mass murder active shooter events. The purpose of this research is not to explore the link between mental illness and violence (a subject about which considerable research has been conducted) and the correlation between mental illness and violence firmly established, given particular antecedent conditions.[67] Instead, the purpose of this research is to examine cues or warning signs that precede an incident of extreme violence perpetrated by a mentally ill person, as well as current clinical approaches to violence risk assessment, in order to improve the practice of law enforcement risk assessment.

To achieve this, the research will involve a comparison of deductively selected cases, and it is intended to explore the causal processes and identify conditional generalizations that can be used to help predict potential outcomes. These cases will include an examination of events where acts of extreme violence were successfully perpetrated by a mentally ill subject, as well as events in which acts of extreme violence were possible but were thwarted by law enforcement through intervention with particular attention paid to LEO receptivity of warning signs and indicators of dangerousness.

---

[67] Eric Silver, *Mental Illness and Violence: The Importance of Neighborhood Context* (New York: LFB Scholarly Publishing LLC, 2001), 52;

Torrey, *The Insanity Offense*, 142–143.

It should be noted that any attempt to develop a simple "attacker profile" would be insufficient for several reasons. For one, while traditional profile attributes such as age and gender are critical to conduct a comprehensive risk assessment, they do not provide the information necessary to develop a profile. Additionally, this research has determined that race or ethnicity appear to play no role in predicting dangerousness and the likelihood of extreme violence. Finally, traditional profiles do not take into consideration specific facts and circumstances that can contribute to dangerousness that are unique to each individual person, such as past history of violence and other criminological risk factors.

It has been said that without generalization, foreknowledge is impossible.[68] Subsequently, cases have been selected and studied to obtain generalizable knowledge and empirical evidence that can then be applied to future law enforcement interactions with mentally ill subjects in order to better gauge dangerousness and the potential for violence.

D. DATA COLLECTION AND SAMPLING METHODOLOGY

The data gathering process involved researching specific mass murder events in order to learn as much as possible about them. Data for sample cases was derived from primary sources, official reports, open source publications, public records, and established literature. Cases selected represent a purposive sample of mass murder events with particular emphasis placed on what was known about the perpetrator prior to the event. These cases were chosen based on the following criteria: 1) the event constituted, or likely would have constituted if successful, a mass murder of four or more persons as defined by the FBI; 2) the perpetrator was known or suspected to have suffered from a serious mental illness as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV);[69] 3) the perpetrator was contacted by law enforcement in the days,

[68] Henri Poincare, *The Foundations of Science: Science and Hypothesis, The Value of Science, Science and Method* (New York: The Science Press, 1913).

[69] See Appendix A for the DSM-IV definition of serious mental illness. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Arlington, VA: American Psychiatric Publishing, 2000).

weeks, or months prior to the event taking place; and 4) there is sufficient information available in public records about the period of time preceding the event to facilitate the research. Subsequently, the sample cases selected for this research were chosen because of the amount of information available about them. Only four cases were selected for analysis in order to complete the research within the allotted time.

The framework for the research into case samples consists of the following boundaries: 1) examination of the time antecedent to the attack, and 2) examination of information that was available to law enforcement officers through observation and standard investigative techniques. Moreover, the examination of case samples will specifically focus on the perpetrator's criminal history, history of mental illness, contact with law enforcement, and the clinical and criminological risk factors that were, or should have been, apparent to law enforcement officers at the time of contact.

While some argue that the nature, quality, and amount of the data relative to extreme acts of violence perpetrated by the mentally ill are insufficient to allow for explanatory statistical modeling and predictability,[70] public safety officials must rely upon the observable facts and empirical evidence as they exist in order to anticipate the potential for violence and take reasonable action to prevent it. Several useful predictors of violence have been established through clinical research. These include history of past violence, age, gender, intelligence, psychiatric disorder and psychopathy, alcohol and drug abuse, and even adverse childhood experiences (ACEs) all influence the propensity for future violence.[71] These will also be examined and compared to the findings in the case studies.

At the conclusion the this research and analysis, the intended goal is to identify warning signs or precursors to violence in order to create a comprehensive field risk assessment tool that can be used by law enforcement officers and other first responders to help assess the risk for extreme violence posed by a particular individual. It is hoped that

[70] Jeffrey W. Swanson, "Explaining Rare Acts of Violence: The Limits of Evidence from Population Research," *Psychiatric Services* 62, no. 11 (2011): 1369–1371.

[71] Leon Bakker, James O'Malley, and David Riley, *Storm Warning: Statistical Models for Predicting Violence*, Psychological Service New Zealand Department of Corrections, 1988, http://www.corrections.govt nz/__data/assets/pdf_file/0005/665609/storm.pdf

the application of empirical data and logical reasoning to the endeavor of law enforcement risk assessments will result in better decision making and possibly preempt extreme violence among subjects suffering from serious mental illness.

IV. POLICE TRAINING AND RESPONSE TO MENTAL ILLNESS

> We must stop criminalizing mental illness. It's a national tragedy and scandal that the L.A. County jail is the biggest psychiatric facility in the United States.
>
> —Elyn Saks

A. LAW ENFORCEMENT'S ROLE IN ASSESSING RISK

Law enforcement calls involving persons suffering from mental illness are on the rise nationally, and according to some estimates, these calls comprise between seven and 10 percent of all police calls for service.[72,] In the majority of communities across the country, law enforcement is the first and often the only community resource that can be called upon to respond and address mentally ill persons in various stages of crisis.[73] This places a significant public safety obligation upon law enforcement officers, as well as the duty to ensure that the mentally ill person receives proper care and treatment for his or her condition.

As previously mentioned, the rationale for law enforcement intervention in non-criminal situations involving mentally ill persons is derived from two common-law principles: the power and authority of police to protect the safety and welfare of the community and the state's parens patriae duty to act on the behalf of citizens who are temporarily or permanently incapable of caring for themselves.[74]

In most communities, a law enforcement officer's options are quite limited when confronted with a mentally ill person. Historically, there have been three choices: arrest,

---

[72] "Law Enforcement and People with Severe Mental Illness," Treatment Advocacy Center, accessed September 1, 2014, http://www.treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/jail/1385; Deane et al., "Emerging Partnerships."

[73] H. Richard Lamb, Linda E. Weinberger, and Walter J. DeCuir, Jr., "The Police and Mental Health," *Psychiatric Services* 53, no. 10 (2002): 1266–1271, accessed August 17, 2014, http://psychiatryonline.org/doi/abs/10.1176/appi.ps.53.10.1266

[74] Ibid.

commit, or attempt to de-escalate.[75] Today, law enforcement officers can typically choose from at least four courses of action:

1. Arrest the person for a criminal offense
2. Initiate an involuntary civil commitment
3. Refer the person to outpatient services
4. Resolve the matter informally

Arresting a mentally ill person for a criminal offense assumes probable cause. This choice is also seen by many clinicians and advocates for the mentally ill as wrongly criminalizing the mentally ill person, who often would not have committed the offense if not for their mental illness.[76] Additionally, some also view the incarceration of the mentally ill as a form of re-institutionalization, a shifting of the mentally ill from state-run mental hospitals to state-run jails and prisons.[77] Unfortunately, arrest is often necessary, if not the best choice in light of the circumstances faced and the options available to officers dealing with a mentally ill person who has committed a criminal offense.

Another option is involuntary civil commitment or the admission of individuals against their will into a mental health unit for evaluation and treatment.[78] Every state has distinct laws governing this process, but all of the state laws comply with rulings handed down by the United States Supreme Court in light of the Constitution. In the landmark case O'Connor v. Donaldson, the court established that states cannot confine a non-dangerous person against their will, so long as they are capable of surviving safely by themselves or with the help of others—the presence of mental illness alone was deemed insufficient grounds for involuntarily committing a person.[79]

---

[75] Abigail S. Tucker, Vincent B. Van Hasselt, and Scott A. Russell, "Law Enforcement Response to the Mentally Ill: An Evaluative Review," *Brief Treatment and Crisis Intervention* 8, no. 3 (2008): 236–250, DOI:10.1093/brief-treatment/mhn014.

[76] Melissa Schaefer Morabito, "Horizons of Context: Understanding the Police Decision to Arrest People with Mental Illness," *Psychiatric Services* 58, no. 12 (2007): 1582–1587.

[77] Gold, "Report: Jails House 10 Times More Mentally Ill than State Hospitals."

[78] Ralph Reisner, Christopher Slobogin, and Arti Rai, *Law and the Mental Health System: Civil and Criminal Aspects* (Berkeley, CA: West Group, 2009), 704–705.

[79] John Parry, "Involuntary Civil Commitment in the 90's: A Constitutional Perspective," *Mental and Physical Disability Law Reporter* 18, no. 3 (1994): 320–336.

O'Connor v. Donaldson created the framework within which all state laws must function, establishing dangerousness to one's self, or to others, as a near absolute requirement for an involuntary civil commitment.[80] Subsequently, in most states an officer may initiate an involuntary commitment when he or she has probable cause to believe that a mentally ill person poses a danger to her or himself or others, is in need of treatment, or unable to care for her or himself adequately (these latter two criteria are ultimately components of an inability to care for one's self). This allows for the detention of the person for up to 72 hours in order for a doctor or other health care professional to determine if involuntary commitment to a mental institution is necessary.

The third option an officer has when dealing with a mentally ill person is that of referring the person to outpatient mental health care services or to a specialized acute care response team, such as the Los Angeles Police Department's System-wide Mental Assessment Response Team (SMART) or Santa Barbara County's Crisis and Recovery Emergency Services unit (CARES). This option is not available in all communities due to a lack of funding and professional personnel resources, but outpatient emergency services are on the increase nationally and have proven an effective tool in stabilizing persons in crisis and avoiding arrest.[81] This is an important option that holds much promise for law enforcement, public safety, and the needs of persons suffering from mental illness, and therefore, it should be a priority for policymakers.

The final option is an informal resolution in which the officer tries perhaps to temporarily mitigate a situation but takes no enforcement or other formal action. Informal resolution is the most frequent option chosen by law enforcement officers. This option frees the officer from being "tied-up" at the scene for a significant length of time and often relieves the officer of the responsibility of having to document his or her actions in written police report.[82]

---

[80] Ibid.

[81] Rob van den Brink et al., "Role of the Police in Linking Individuals Experiencing Mental Health Crises with Mental Health Services," *BMC Psychiatry* 12, no. 171 (2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3511214/

[82] Linda A. Teplin, "Keeping the Peace: Police Discretion and Mentally Ill Persons," *National Institute of Justice Journal* 244 (July 2000): 8–15.

According to a study conducted in 1980, researchers found that police calls for service involving mentally ill persons were resolved informally 72 percent of the time, a criminal arrest was made 16 percent of the time, and proceedings for an involuntary commitment were initiated 12 percent of the time.[83] As already mentioned, referral to outpatient or other community treatment is a relatively new option not widely available at the time of the aforementioned study.

B. MENTAL ILLNESS AND THE STATE OF LAW ENFORCEMENT TRAINING

As discussed throughout this thesis, law enforcement officers are regularly called to incidents involving mentally ill persons. In these situations, the police function not only as public safety officers, but social workers, emergency health care responders, triage decision makers, inter-agency liaisons, and providers of transportation and other services.[84] In spite of these demands and the liability inherent in dealing with persons with mental illness, most law enforcement officers receive little training to equip them for interaction with the mentally ill and even less training to equip them in conducting a risk assessment for potential violence. According to a study of 70 participating law enforcement agencies conducted in 2003, the median number of training hours for new recruits was 6.5 hours, while the median for in-service training was a paltry one-hour of training.[85] Given the frequency and sheer volume of calls for service involving persons with mental illness, this is unacceptable, and it has opened many agencies up to public criticism, civil liability, and accusations of deliberate indifference with regard to the mentally ill.[86]

---

[83] EP Sheridan, and L. Teplin, "Police-referred psychiatric emergencies: advantages of community treatment," *Journal of Community Psychology* 9, no. 2 (1981): 140–147.

[84] Wood et al., *Police Interventions*, 6.

[85] Judy Hails, and Randy Borum, "Police Training and Specialized Approaches to Respond to People with Mental Illnesses," *Crime and Delinquency* 49, no. 52 (2003): 52–61.

[86] Michael S. Woody, "Dutiful Minds: Dealing with Mental Illness," CIT International, January 6, 2003, accessed September 1, 2014, http://www.citinternational.org/training-overview/129-dutiful-minds-dealing-with-mental-illness html

C. CRISIS INTERVENTION TEAMS AND OTHER APPROACHES

In response to the challenges posed by persons with mental illness, most agencies have responded in one of four ways: 1) no specialized training or response to persons with mental illness; 2) police-based specialized police response, in which select officers receive specialized training in dealing with the mentally ill; 3) police-based specialized mental health response, in which mental health professionals are employed by an agency to provide consultations; and 4) mental-health-based specialized mental health response, which include cooperative agreements between police and mobile mental health crisis teams (MCTs) that operate independent of the law enforcement agency.[87]

According to a study of law enforcement agencies typology of response conducted by Deane et al. in 1999, of 174 responding agencies,[88] 55 percent of the LEAs had no specialized response program. The results of this study can be found in Figure 2.

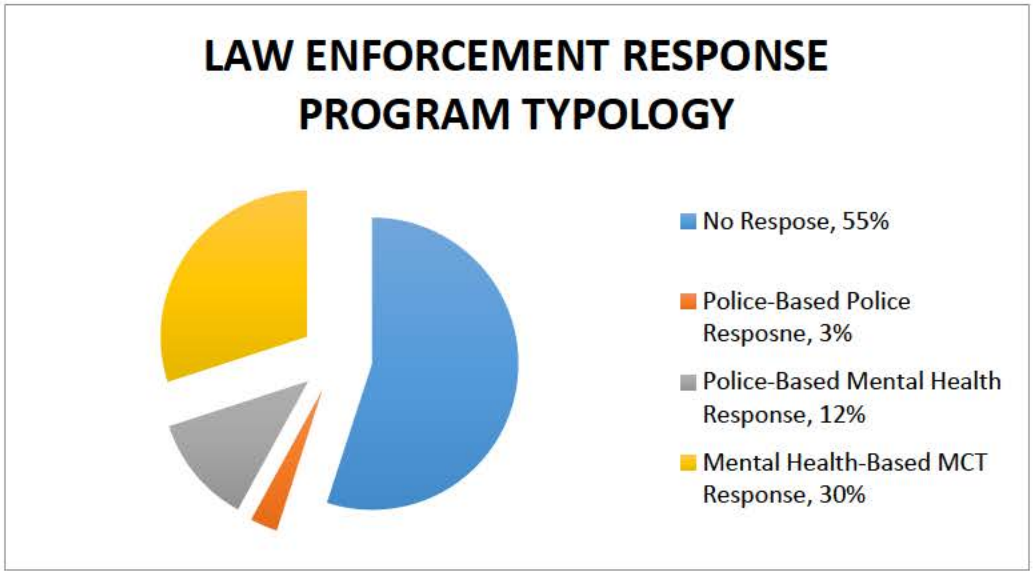

Figure 2. Program Response Typology—Specialized Responses to Persons with Mental Illness.[89]

[87] Hails, and Borum, "Police Training and Specialized Approaches," 54.

[88] Deane et al., "Emerging Partnerships," 100.

[89] Deane et al., "Emerging Partnerships," 100.

Now, nearly 15 years since this study was conducted, the police response to persons with mental illness is by far the most common. This is due primarily to more agencies recognizing the need for a specialized response to persons with mental illness and the relative cost effectiveness of this approach. By far the most popular police-based police response program is the crisis intervention team model.

The first crisis intervention team was developed by the Memphis Police Department in 1987 following public outcry over the fatal police shooting of a 27-year-old mentally ill man armed with a knife.[90] Now, crisis intervention teams (CITs) are sweeping the country and can be found in most major cities from San Francisco, California, to Albuquerque, New Mexico, to Washington, D.C., with dozens of other law enforcement agencies implementing similar programs.[91]

Consisting of 40-hours of specialized training designed to assist law enforcement officers confronted with a mentally ill person in crisis, CIT is considered to be the most comprehensive law enforcement mental health training program in the country.[92] Additionally, while most agencies that adopt CIT cannot afford the time or resources to train all officers, most agencies try to train enough personnel to ensure there is at least one CIT trained officer on duty at all times.[93]

The CIT approach to handling mental illness essentially focuses on three goals: 1) training officers to recognize mental illness and de-escalate situations involving mentally ill persons in crisis; 2) forging partnerships between law enforcement and mental health care providers; and 3) reducing the number of mentally ill persons arrested and booked into jails. The CIT approach offers training for everyone connected with the response to mentally ill persons in crisis, from call-takers and dispatchers, to mental health care

---

[90] Betsy Vickers, *Memphis, Tennessee Police Department's Crisis Intervention Team, Practitioners Perspectives* (Washington, DC: U.S. Department of Justice, 2000), accessed August 26, 2014, https://www.ncjrs.gov/pdffiles1/bja/182501.pdf

[91] Hails, and Borum, "Police Training and Specialized Approaches," 59.

[92] Megan Pauly, "How Police Officers Are (or Aren't) Trained in Mental Health," *The Atlantic*, October 11, 2013, accessed September 1, 2014, http://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/

[93] Ibid.

providers, to jail officers, but its primary focus is to equip patrol personnel to better handle the unique challenges of dealing with a mentally ill person. The weeklong curriculum is well regulated and must cover the following subjects:

CIT Patrol Officer 40-Hour Comprehensive Training Curriculum:[94]

1) Didactics and Lectures/Specialized Knowledge

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post-Traumatic Stress Disorders (PTSD)
- Legal Aspects of Officer Liability
- Community Resources

2) On-Site Visits and Exposure

- On-Site Visits

3) Practical Skill Training/Scenario Based

- Crisis De-Escalation Training Part I

Basic Strategies

- Crisis De-Escalation Training Part II

Basic Verbal Skills

- Crisis De-Escalation Training Part III

Stages/Cycle of a Crisis Escalation

- Crisis De-Escalation Training Part IV

[94] DuPont et al., *Crisis Intervention Team Core Elements.*

Advanced Verbal Skills

- Crisis De-Escalation Training Part V

Advanced Strategies: Complex Scenarios

As can be clearly seen in the CIT curriculum, principal emphasis is placed on advocacy, mental health care services, and violence avoidance through de-escalation. While these are important elements of an agency's approach to dealing with persons with mental illness, the critical responsibilities of public safety and violence risk assessment are strikingly absent from the training.

In spite of these shortcomings, the 40-hour CIT program represents the gold standard in law enforcement training for dealing with mentally ill persons. An alarming study published in 2003 found that among 84 agencies surveyed, a median of 6.5 hours of specialized training was provided to new recruits, and only one hour of training was provided for in-service personnel.[95]

D. LAW ENFORCEMENT DISCRETION AND RISK ASSESSMENT

Law enforcement officer discretion, or the process of how an individual officer decides what enforcement action to take in a particular instance, has long been a topic of discussion and study. In 1967, Egon Bittner published a significant study of police officer discretion and interaction with the mentally ill. Furthermore, Bittner identified three domains that he termed "horizons of context" that affect police decisions regarding whether or not to arrest a person with mental illness, as shown in the Figure 3.[96]

[95] Hails, and Borum, "Police Training and Specialized Approaches," 52.

[96] Egon Bittner, "Police Discretion in Emergency Apprehension of Mentally Ill Persons," *Social Problems* 14, no. 3 (1967): 278–292.

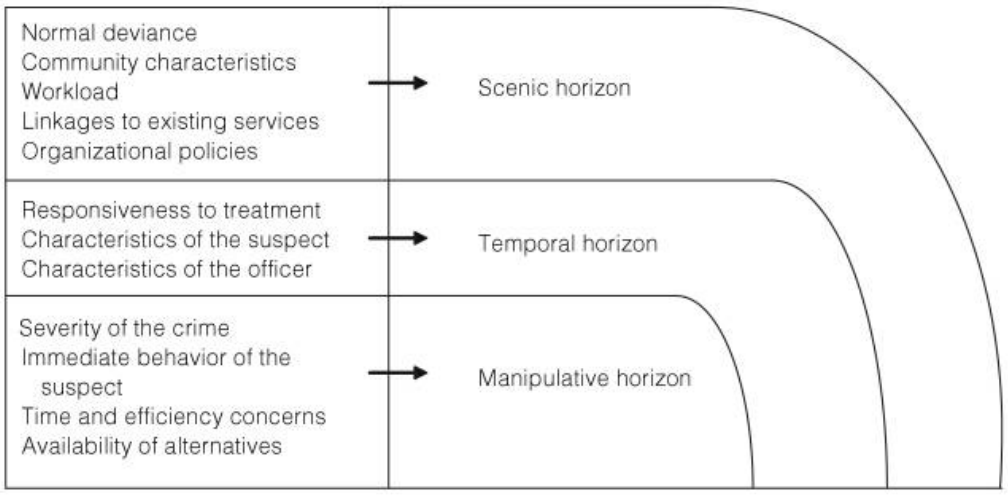

Figure 3. Horizons of Context—Inclusive Elements that Help to Explain the Police Decision to Arrest People with Mental Illness.[97]

The scenic horizon includes several environmental factors that tend to influence the person suffering from mental illness. These include the law enforcement agency's norms, policies, and approach to persons with mental illness, the community's baseline for "normal deviance" (or an estimate of how much disorder a particular community will traditionally tolerate), the officer's workload, and specific environmental factors affecting the mentally ill person, such as the presence or absence of a stable family and home-life that could serve to support and monitor the person.[98] In addition, the temporal horizon includes police knowledge that expands beyond the specific incident. Factors found within the temporal horizon include specific officer characteristics, such as specialized training and experience, the characteristics of the person in crisis, such as age, gender, or a history of substance abuse, and the specific mental health needs of the person.[99]

The manipulative horizon includes factors that are based on the immediate situation at hand. These include the severity of the offense or situation, the immediate behavior of the person, time constraints (whether real or artificial) and the availability of options, which range from arrest, to an informal disposition, to a referral to a treatment

[97] Morabito, "Understanding the Police Decision to Arrest," 1584.

[98] Ibid.

[99] Ibid.

center, or, in rare situations, to call a CIT or other specialized forensic mental health team to respond.[100]

Bittner's observations and research regarding police discretion and the process of deciding whether to arrest or not, is informative. Moreover, they can be used to examine police decisions following both completed violent events, and those that were thwarted. It also illustrates the complexity in examining police discretion.

E. BEHAVIORAL THREAT ASSESSMENTS AND THE MENTALLY ILL

During the 1990s, Robert A. Fein, a clinical psychologist with the U.S. Secret Service, and Bryan Vossekuil, a special agent with the Secret Service, conducted the Exceptional Case Study Project, which employed an incident focused, behavior-based approach analyzing 83 persons known to have engaged in 73 incidents of assassination, near assassination, or attack on public officials from 1949 to 1995.[101] There findings, published in 1998 and titled *Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials*, established that while there was no profile of the typical assassin, there were common, discernable process of attack-related thinking and behavior in targeted violence that could be observed, and acted upon.[102] As a result of their research, Fein and Vossekuil identified a list of questions to ask while conducting a threat assessment of possible targeted violence towards a public official or other person.

---

[100] Ibid.

[101] "National Threat Assessment Center," U.S. Secret Service, accessed October 2, 2014, http://www.secretservice.gov/ntac.shtml

[102] Ibid.

Table 2. U.S. Secret Service "Questions to Ask in a Threat Assessment"[103]

I.	Has the subject shown an interest in any of the following? • Assassins or assassination. • Weapons (including recent acquisition of a weapon). • Militant or radical ideas/groups. • Murders, murderers, mass murderers, and workplace • Violence and stalking incidents.
II.	Is there evidence that the subject has engaged in menacing, harassing, and/or stalking-type behaviors? Has the subject engaged in attack related behaviors? These behaviors combine an inappropriate interest with any of the following: • Developing an attack idea or plan. • Approaching, visiting, and/or following the target. • Approaching, visiting, and/or following the target with a weapon. • Attempting to circumvent security. • Assaulting or attempting to assault a target.
III.	Does the subject have a history of mental illness involving command hallucinations, delusional ideas, feelings of persecution, etc., with indications that the subject has acted on those beliefs?
IV.	How organized is the subject? Does the subject have the ability to plan and execute a violent action against a target?
V.	Is there evidence that the subject is experiencing desperation and/or despair? Has the subject experienced a recent personal loss and/or loss of status? Is the subject now, or has the subject ever been, suicidal?
VI.	Is the subject's "story" consistent with his or her actions?
VII.	Are those who know the subject concerned that he or she might take action based on inappropriate ideas?
VIII.	What factors in the subject's life and/or environment might increase or decrease the likelihood that the subject will attempt to attack a target (or targets)?

The work done by Fein and Vossekuil has served as the foundation for further behavioral threat assessment research, which includes an examination of school and other

[103] Robert A. Fein, and Bryan Vossekuil, *Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials* (Washington, DC: U.S. Department of Justice, 1998).

active shooter events. This has led to the development of a more expansive list of warning behaviors:[104]

1. Pathway warning behaviors
2. Fixation warning behaviors
3. Identification warning behaviors
4. Novel aggression warning behaviors
5. Energy burst warning behaviors
6. Leakage warning behaviors
7. Last resort warning behaviors
8. Direct threat warning behaviors

But while there are similarities, behavioral threat assessments differ from the violence risk assessment law enforcement is expected to conduct when dealing with a mentally ill person in crisis in regards to the goals, context, process, structure, and, most importantly, time horizon.[105] Furthermore, behavioral threat assessments are aimed at persons who are at some point along a path of targeted violence against a specific target, whereas violence risk assessments attempt to assess the likelihood of violence posed by a mentally ill person, against anyone, as well making a determination as to how soon that violence might occur.

F. CLASSICAL APPROACH TO RISK ASSESSMENT

Another consideration is the classical approach to risk assessment adopted by the Department of Homeland Security for counter-terrorism infrastructure protection. This simple formula determines the level of risk by examining the probability that the perpetrator would attack, the probability that the perpetrator would be successful, and the consequence of a successful attack in persons likely killed or injured. This model is expressed as the equation, R = T x V x C and is used primarily within the Department of Homeland Security for infrastructure and asset protection against terrorist threats. However, this method of risk assessment is not ideal for a number of reasons, foremost

[104] J. Reid Meloy, and Jens Hoffmann, *International Handbook of Threat Assessment* (New York: Oxford University Press, 2014), 39–40.

[105] Ibid., 13.

being the intrinsic subjectivity and ambiguity of establishing a numeric value for such concepts as threat, vulnerability, and consequence, especially by law enforcement officers in a field setting.

THIS PAGE INTENTIONALLY LEFT BLANK

V. SUMMARY CASE STUDIES

> People with mental problems are almost never dangerous. In fact, they are more likely to be the victims than the perpetrators. At the same time, mental illness has been the common denominator in one act of mass violence after another.
>
> —U.S. Senator Roy Blunt

A. WASHINGTON NAVY YARD

During the early morning hours of August 6, 2013, Naval Station Newport Police received several calls from the Navy Gateway Inns & Suites regarding a noise complaint. The front desk clerk requested police respond for fear that a guest, who was behaving very strangely, might hurt someone. Naval Station Newport Police responded, and officers met with a distraught man who had taped a microphone to the ceiling of his room in order to record the voices of people that he believed were following him.

The man, identified as 34-year-old Aaron Alexis, was a U.S. Navy veteran trained in aviation electronics and recently employed by a military sub-contractor because of his training and security clearance. However, Alexis was a deeply troubled person. His aggressive behavior in the military had resulted in a general discharge for misconduct, and he had recently sought help at a Veteran's Administration Hospital for acute insomnia.[106] Those closest to Alexis described him as a "13-year-old stuck in a 34-year-old body" and an alcoholic with a fierce temper, who carried a gun with him wherever he went.[107]

Now, at the Navy Gateway Inns & Suites, Alexis was clearly in distress; he had dismantled his bed, fearing someone was hiding beneath it. He told officers that he feared that "they" might have implanted a chip in his head. Naval Station Newport officers tried

---

[106] Theresa Vargas, Steve Hendrix, and Marc Fisher, "Aaron Alexis, 34, is Dead Gunman in Navy Yard Shooting, Authorities Say," *The Washington Post*, September 17, 2013, accessed August 12, 2014, http://www.washingtonpost.com/politics/aaron-alexis-34-is-dead-gunman-in-navy-yard-shooting-authorities-say/2013/09/16/dcf431ce-1f07-11e3-8459-657e0c72fec8_story html

[107] Ibid.

to calm Alexis, but they eventually cleared the call without taking any action, having determined Alexis was not a threat or in need of "immediate care or treatment."[108]

One day later, on the morning of August 7, 2013, Newport, Road Island Police were dispatched to a routine, low-priority call of harassment at the Marriott Hotel. Upon arrival, they too met with Alexis. He again displayed signs of paranoid delusions and told police that people whom he could hear talking through the walls of his room were following him. Additionally, Alexis explained to the officers that the people had been sent to harass him and to keep him from sleeping by using a microwave to send vibrations through his body. Finally, a desperate and delusional Alexis told the officers that he was afraid and feared that these people were planning to hurt him.

The officers surmised that Alexis was delusional and likely suffering from some form of mental illness; however, the Newport Police officers also cleared the call without taking any action. Instead, they advised Alexis to stay away from the people, whom the officers clearly believed did not exist and told him to call again should he have any contact with them. The officers then wrote a half-page report documenting the incident and submitted it to a sergeant who forwarded the report on to the Naval Station Newport Police as a courtesy due to the man's occupation.[109]

Less than six weeks later, on September 16, 2013, Aaron Alexis entered the Washington Navy Yard at 8:20 in the morning, carrying a concealed sawed-off shotgun, a rifle, and a semi-automatic handgun. Alexis proceeded to shoot 16 people, killing 12 of them before he was finally shot and killed by responding officers.

B. ISLA VISTA, CALIFORNIA

On July 21, 2013, Santa Barbara County sheriff's deputies responded to the Goleta Valley Cottage Hospital for a battery report. Upon arrival, they met with the victim, a 21-year old man named Elliot Rodger who claimed he had been battered while

[108] U.S. Department of the Navy, *Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices*, November 8, 2013, http://www.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

[109] Newport Police Department report 13-17827, August 7, 2013. Internal document.

at a party in Isla Vista, California. Described as "timid, and shy" by officers, Rodger did not display any overt signs of mental illness; however, during the course of the subsequent investigation, the deputies learned that Rodger had actually tried to push two women from a 10-foot balcony while at the party, prompting the altercation.[110] Deputies also learned from witnesses that Rodger was behaving "strangely" while at the party, and he did not appear to be socializing with anyone. Deputies closed the case without any further follow-up or action.[111]

On April 30, 2014, Rodger was again contacted by deputies from the Santa Barbara Sheriff's Department, along with a University of California, Santa Barbara police officer, and a dispatcher in training. This time, officers arrived at Rodger's home after receiving a call from a county mental health care worker and therapist to the young man,[112] expressing fear and alarm over his behavior and disturbing videos that he had posted on YouTube indicating suicidal and homicidal ideations.[113] Deputies, who spoke to Rodger at the door of his residence, again described a timid and shy young man with no obvious signs of mental illness. Deputies did not look at the disturbing videos that had prompted the call, nor did they ask to go inside the residence, nor take any other reasonable investigative steps to learn more about this young man.[114]

On May 23, 2014, Rodger executed the murder spree that he had been planning for months. When it was over, Elliot Rodger had killed six and wounded 13 before taking his own life. In the aftermath of Rodger's murderous rampage, Santa Barbara Sheriff Bill Brown told reporters that it was "very, very apparent that he [Rodger] was severely

---

110 Santa Barbara Sheriff's Office report 13-10081, July 21, 2013. Internal document.

111 Ibid.

112 Suman Varandani, "California Police Knew of Elliot Rodger's Disturbing Videos Days before His Shooting Spree but Did Not Watch Them," *International Business Times*, May 30, 2014, accessed August 25, 2014, http://www.ibtimes.com/california-police-knew-elliot-rodgers-disturbing-videos-days-his-shooting-spree-did-not-1592327

113 "Virgin Killer's Parents Read His Hate-filled Manifesto then Called the Police and Rushed to Stop him When They Heard of Murder Spree on Their Car Radio," *Mail Online*, May 25, 2014, accessed August 25, 2014, http://www.dailymail.co.uk/news/article-2639177/Parents-shooter-read-manifesto-driving-stop-son-heard-massacre-radio-revealed-investigators-search-moms-house.html

114 Varandani, "California Police Knew of Elliot Rodger's Disturbing."

mentally disturbed."[115] In spite of this observation, the sheriff went on to announce that the deputies who responded had handled the call in a professional manner "consistent with state law and department policy."[116] In the months following the Isla Vista mass-murders, a spokeswoman for the Santa Barbara Sheriff's Department struggled to explain how Rodgers did not pose an "immediate threat," leaving deputies no choice under state law but to clear the call without taking any action or making any referral.[117]

C. DE ANZA COLLEGE

On January 29, 2001, 19-year-old college student Al DeGuzman arrived at the Longs Drug Store on Berryessa Road in San Jose California to pick up the photographs he had left a day earlier to be developed. He provided the clerk with his receipt, and waited for her to retrieve his photos. While waiting for the clerk to return, two officers with the San Jose Police Department approached DeGuzman from the back of the store. DeGuzman, spooked, tried to walk away, but was quickly detained by the officers before he could leave the store.[118]

The clerk, an 18-year-old college student at San Jose State, had developed DeGuzman's role of film earlier that day and was deeply troubled by what she saw. Images of DeGuzman posing with weapons and pipe bombs prompted the clerk to call the police and report what she had seen. The clerk would later tell reporters, "The anger in his face scared me."[119] Police responded in time to intercept DeGuzman at the photo-lab. During a subsequent search of DeGuzman's home, police found four rifles, a sawed-off shotgun, 30 pipe bombs, 20 Molotov cocktails and 2,000 rounds of ammunition, a

---

[115] "Gunman Emailed Plans to Parents before Rampage," *Chicago Tribune*, May 26, 2014, http://articles.chicagotribune.com/2014-05-26/news/chi-santa-barbara-shooting-20140525_1_isla-vista-uc-santa-barbara-childhood-friend

[116] Joshua Molina, "Elliot Rodger and a Call for Help," Mission and State, June 4, 2014, accessed August 25, 2014, http://www missionandstate.org/homepage-layout/featured-story-center/elliot-rodger-call-help/

[117] Ibid.

[118] Alex Ionides, "This Boy's Plan," *Metroactive*, January 31, 2002, accessed August 26, 2014, http://www.metroactive.com/papers/metro/01.31.02/cover/deguzman-0205.html

[119] John M. Glionna, and Rebecca Trounson, "Man Accused of Bombing Plot Hated Everyone," *Los Angeles Times*, February 1, 2001.

map of De Anza College marked with locations where he planned to plant the bombs, and a tape recording outlining his plot to attack the school.[120]

In the days following his arrest, police learned that DeGuzman had been planning to attack De Anza College for years, was obsessed with Columbine killers Eric Harris and Dylan Klebold, and was only one day away from carrying out his plans when he was arrested.[121] DeGuzman had no prior arrest record and was a good student, who was well liked by all who knew him; however, DeGuzman suffered from major depression and suicidal ideations from the age of 15. He was never treated for the disorder.[122] DeGuzman was later found guilty on 108 felony chargers and sentenced to 80 years in state prison. On Monday, August 9, 2004, Al DeGuzman committed suicide by hanging himself in his Folsom State Prison cell.[123]

Acting on nothing more than some suspicious photographs, a drug store clerk and a couple of police officers prevented what would have certainly been another school shooting. Why did these officers handle this call the way they did? In a city of more than a million people, it would not have been surprising for the officers to resolve the matter informally—to simply interview DeGuzman, and, as in the case of Elliot Rodgers, let the quiet, unassuming young man go without searching his home or digging beneath the surface to uncover his murderous plot.

D. GARDNERVILLE, NEVADA

On Monday, March 11, 2013, the Douglas County Communications Center in Minden, Nevada received a call on the non-emergency line at 3 a.m. from a woman who reported that her 27-year-old son had left a note stating, "Mom, you need to call the

---

[120] Maria Alicia Guara, Matthew B. Stannard, and Stacy Fin, "De Anza College Blood Bath Foiled—Photo Clerk Calls Cops," SF Gate, January 31, 2001, accessed June 28, 2014, http://www.sfgate.com/bayarea/article/De-Anza-College-Bloodbath-Foiled-Photo-Clerk-2957361.php

[121] Glionna, and Trounson, "Man Accused of Bombing Plot Hated Everyone."

[122] Alex Ionides, "DeGuzman Trial Delayed," *LaVoz Weekly*, November 13, 2001, accessed August 26, 2014, http://lavozdeanza.com/uncategorized/2001/11/13/deguzman-trial-delayed/

[123] "Man Who Planned Massacre at De Anza College Commits Suicide," SF Gate, August 9, 2004, accessed August 26, 2014, http://www.sfgate.com/news/article/Man-who-planned-massacre-at-De-Anza-College-2702611.php

police. I'm seriously thinking about killing these people."[124] The caller explained that her son was delusional and that he was hearing voices that were telling him to kill their neighbors.[125] The caller further reported that her son suffered from paranoid schizophrenia, slept with a loaded AR-15 rifle, and had previously threatened to kill her with scissors.[126] The caller refused to give her name or location, and deputies on patrol that morning were unable to identify or locate the caller.

Given the strange nature of the call and the potential for serious violence, investigators chose to follow-up on the call the next day. From clues left by the caller while talking on the phone, specifically her son's first name, his therapist's name, and the fact that he recently been incarcerated in the Douglas County Jail, investigators identified the caller and her son Michael Tom. Investigators conducted a check of Tom's criminal history and prior contacts with law enforcement and found numerous reports dating back a decade that included two involuntary civil commitments for mental illness, four reports of domestic battery, and one arrest for possession of a firearm while under the influence of alcohol and marijuana.[127]

Thus informed, investigators went to Tom's residence and upon arrival met with Tom's family, who were initially reluctant to cooperate with law enforcement. Family members expressed concerns that Tom needed psychiatric help, not incarceration in jail. Investigators likewise expressed their concerns for Tom, his family, and the community. Tom's mother was eventually persuaded to talk to investigators, although his father remained uncooperative throughout the investigation. According to Tom's mother, Tom was paranoid and believed the neighbors were conspiring against him and harassing him. She further stated that Tom has been abusing alcohol, and she was unsure if he was taking the medications he was prescribed to treat his schizophrenia.[128] In addition, Tom's mother told investigators that he had recently begun to hear voices and see people that

[124] Sheila Gardner, "Man Accused of Threatening Neighbors," *The Record Courier*, March 29, 2013

[125] Ibid.

[126] Ibid.

[127] Douglas County Sheriff's Office (Minden, Nevada) report 13SO06841, March 11, 2013. Internal document.

[128] Ibid.

did not really exist. She also told investigators that Tom gets violent when he is in one of these "altered" states, and that she was afraid of him.[129]

Investigators eventually interviewed Tom himself. Tom told investigators that he had been drinking alcohol, and that he was schizophrenic. In addition, Tom told investigators that his neighbors were "out to get him" and later stated he heard voices telling him to kill his neighbors before they killed him. Tom admitted that he had been sleeping with a loaded AR-15 rifle for the last month for protection from his neighbors. An AR-15 rifle and a semi-automatic handgun were seized from Tom's bedroom and taken for "safekeeping." Furthermore, Tom was taken into custody, and investigators initiated the application process for an emergency involuntary civil commitment. [130]

Investigators, working in conjunction with the District Attorney's Office, convinced a judge to use an obscure Nevada law to require Tom to post a bond as surety to keep the peace.[131] Since Tom had technically not yet violated any law, law enforcement officials were unable to prevent Tom's firearms from being returned to him. However, by requiring Tom to post surety to keep the peace, he was forced to sell his firearms in order to raise the surety. Tom was also placed under the supervision of the Department of Alternative Sentencing and forbidden from obtaining or possessing firearms as a condition of his release.[132]

---

[129] Ibid.

[130] Ibid.

[131] NRS 170.040, Intervention of officers of justice by requiring surety to keep peace, states, "Public offenses may be prevented by the intervention of the officers of justice by requiring surety to keep the peace." Nevada Law Library, "Nevada Revised Statutes," Carson City, Nevada, accessed June 17, 2013. https://www.leg.state nv.us/NRS/NRS-170 html

[132] "Bail Reduced for Man who Threatened Neighbors." *The Record Courier*, April 13, 2013.

THIS PAGE INTENTIONALLY LEFT BLANK

VI. CLINICAL VIOLENCE RISK ASSESSMENT

> I had noticed that both in the very poor and very rich extremes of society the mad were often allowed to mingle freely.[133]

A. BACKGROUND

Since the deinstitutionalization of persons suffering from severe mental illness nearly half a century ago, clinicians have been increasingly called upon to assess the potential risk for violence posed by mentally ill persons. Most often, these clinical risk assessments for violence are used within the framework of the legal system in order to inform decisions regarding the sentencing, parole, application of the death penalty, civil commitment, and discharge from custody of persons having or suspected of having some form of mental illness.[134]

More recently, in the wake of numerous studies and years of research, the way mental health professionals view and conduct risk assessments has changed significantly:

> Conceptually, there has been a shift from the violence prediction model, where dangerousness was viewed as dispositional (residing within the individual), static (not subject to change) and dichotomous (either present or not present) to the current risk assessment model where dangerousness or ``risk'' as a construct is now predominantly viewed as contextual (highly dependent on situations and circumstances), dynamic (subject to change) and continuous (varying along a continuum of probability).[135]

The importance in this shift from a dichotomous, dispositional view of risk to a more comprehensive, contextual view of risk cannot be overstated. Unfortunately, to the limited degree law enforcement officers perform risk assessments in the field, they are predominantly dichotomous in nature—the persons contacted currently pose a risk to themselves or others, or they do not. As we have seen from the case samples, this simplistic approach is not sufficient to prevent acts of violence.

---

[133] Charles Bukowski, *Ham on Rye* (Santa Rosa: Black Sparrow Press, 1982).

[134] Conroy, and Murrie, *Forensic Assessment*.

[135] Borum et al., “Threat Assessment,” 323–337.

Mental health care practitioners today have at their disposal two primary methods for conducting violence risk assessments—clinical, and actuarial. Clinical risk assessment is the method historically used by mental health professionals to assess the risk for violence in persons with mental illness. The clinical approach involves the clinician's professional judgment based on the synthesis and analysis of test data, interview information, and historical data and is a relatively unstructured approach allowing the clinician to consider anything he or she believes is relevant to the assessment.[136]

On the other hand, actuarial approaches to violence risk assessment rely on statistical formulas and are described by some as being more evidence based and objective. Actuarial models seek to minimize the judgment and discretion of the clinician, which some argue can be flawed and subjective and relies on the insertion of gathered data into a pre-existing equation, which provides a consistent and objective assessment of risk.[137]

So, in essence, clinical assessments tend to be subjective and experiential, while actuarial assessments are statistical in nature. But no approach is without its flaws, and, as Randy Otto observes, the clinical and actuarial approaches need not be mutually exclusive:

> I recommend that clinicians use a combined approach whereby they familiarize themselves with the empirical literature regarding risk factors for violent behavior and structure their inquiry and judgments around these factors.[138]

While there is ongoing debate within the clinical field as to which method is preferred, what is important to note is that there have been numerous studies and risk assessment tools developed by clinicians over the past several decades. Furthermore, though clinical violence risk assessment is an evolving field of study with somewhat mixed results, what has been conclusively established is that: 1) violence does occur with

---

[136] Randy Otto, "Assessing and Managing Violence Risk in Outpatient Settings," *Journal of Clinical Psychology* 56, no. 10 (2000): 1239–1262.

[137] Ibid.

[138] Ibid.

some degree of frequency among persons with mental illness; 2) that persons with certain mental disorders and symptom clusters are more likely to engage in violent behavior than persons without such; and 3) mental health professionals have some ability to assess the risk for violence among persons with mental disorder.[139] As no single risk assessment instrument has emerged as the definitive tool for predicting violence,[140] this research will consider three of the more prominent models.

B. MACARTHUR VIOLENCE RISK ASSESSMENT STUDY

The *MacArthur Violence Risk Assessment Study* (VRAS), made public in April 2001, is the result of nearly 10 years of research into the problem of accurately assessing the risk for violence among the mentally ill. The study was led by University of Virginia Professor John Monahan, with financial support from the MacArthur Foundation, and had the goal of providing clinicians accurate statistical information on the empirical relationships between various risk factors and subsequent violent behavior.[141]

According to the VRAS, risk factors are broken into four primary categories: personal or demographic risk factors, historical risk factors, contextual risk factors, and clinical risk factors. The VRAS identified a number of risk factors as being significantly related to violence, given in Table 3.

---

[139] Ibid.

[140] Arthur J. Lurigio, and Andrew J. Harris, "Mental Illness, Violence, and Risk Assessment: An Evidence-Based Review," *Victims and Offenders* 4 (2009): 341–347.

[141] *The MacArthur Violence Risk Assessment Study*, MacArthur Research Network on Mental Health and the Law, 2001, accessed May 28, 2014, http://macarthur.virginia.edu/risk.html

Table 3. Major Violence Risk Factors MacArthur Violence Risk Assessment Study[142]

Prior arrests Seriousness Frequency	**Demographic** Age (-) Male Unemployed
Child abuse Seriousness Frequency	**Diagnosis** Antisocial PD Schizophrenia (-)
Father Used drugs Home until 15 (-)	**Other Clinical** Substance Abuse Anger control Violent fantasies Loss of consciousness Involuntary status

The *MacArthur Violence Risk Assessment Study* measured 134 risk factors for violence in a population sample of 1,136 persons between the ages of 18 and 40, of diverse ethnicity, who were admitted to acute civil inpatient facilities in select cities in Pennsylvania, Missouri, and Massachusetts.[143] Participants in the study were assessed for risk of violence and following release were monitored for violence for 20 weeks. At the conclusion of the study, the following risk factors were found to be significantly related to violence:[144]

> ***Gender.*** Men were somewhat more likely than women to be violent, but the difference was not large. Violence by women was more likely than violence by men to be directed against family members and to occur at home, and less likely to result in medical treatment or arrest.
>
> ***Prior violence.*** All measures of prior violence—self-report, arrest records, and hospital records—were strongly related to future violence.

[142] Ibid.

[143] MacArthur Research Network on Mental Health and the Law, "The MacArthur Violence Risk Assessment Study," accessed May 28, 2014, http://macarthur.virginia.edu/risk html.http://www.macarthur.virginia.edu/read_me_file html

[144] Ibid.

Childhood experiences. The seriousness and frequency of having been physically abused as a child predicted subsequent violent behavior, as did having a parent—particularly a father—who was a substance abuser or a criminal.

Neighborhood and race. While there was an overall association between race and violence, African Americans and whites that lived in comparably disadvantaged neighborhoods had the same rates of violence.

Diagnosis. A co-occurring diagnosis of mental illness or personality disorder and substance abuse was strongly predictive of violence.

Psychopathy. Psychopathy,[145] as measured using Hare's PCL-R Psychopathy Checklist, was more strongly associated with violence than any other risk factor studied.

Paranoid Delusions. The presence of delusions was not associated with violence, however a generally "suspicious" attitude toward others was

Hallucinations. Voices specifically commanding a violent act increase the likelihood of violence.

Violent thoughts. Thinking or daydreaming about harming others was associated with violence, particularly if the thoughts or daydreams were persistent.

Anger. The higher a patient scored on the Novaco Anger Scale in the hospital, the more likely he or she was to be violent later in the community.[146]

While highly accurate compared to other approaches, the VRAS is also much more computationally complex and involves five tree-based prediction models, each assessing numerous risk factors. [147] Subsequently, the VRAS typically requires software-based administration and scoring and does not lend itself to use in a field setting.

---

[145] Dr. Robert Hare describes psychopathy as "a cluster of personality traits and socially deviant behaviors glib and superficial charm, egocentricity; selfishness, lack of empathy, guilt, and remorse, deceitfulness and manipulativeness; lack of enduring attachment to people, principles, or goals; impulsive and irresponsible behavior, and a tendency to violate explicit social norms." Tom Chivers, "Psychopaths, How Can You Spot One?" *The Telegraph*, April 6, 2014, accessed June 28, 2014, http://www.telegraph.co.uk/culture/books/10737827/Psychopaths-how-can-you-spot-one.html?fb

[146] Ibid.

[147] *The MacArthur Violence Risk Assessment Study*.

C. HISTORICAL, CLINICAL, RISK MANAGEMENT-20

The Historical, Clinical, Risk Management (HCR-20) is a clinical tool that was developed in 1995 through consideration of empirical literature concerning factors related to violence. The HCR-20 was designed to integrate the experience of clinicians, and simplify the administration, and interpretation of the results.[148] In addition, the HCR-20 provides clinicians with 20 violence risk factors, broken down into ten past risk factors, five present risk factors, and five future risk factors, which must be considered when assessing the risk for violence. See Table 4.

[148] "HCR-20 Violence Risk Assessment Scheme: Overview and Annotated Bibliography," University of Massachusetts Medical School, last updated November 24, 2008, http://www.umassmed.edu/Global/Center%20for%20Mental%20Health%20Services%20Research/Documents/Products%20Publications/Reports/Adult%20Criminal%20Justice/HCR-20%20VIOLENCE%20RISK%20ASSESSMENT%20SCHEME%20OVERVIEW%20AND%20ANNOTATED%20BIBLIOGRAPHY.pdf

Table 4. HCR-20 Assessment Items

A.	Historical Items	
	1.	Previous violence
	2.	Young age at first violent incident
	3	Relationship instability
	4	Employment problems
	5	Substance use problems
	6	Major mental illness
	7	Psychopathy
	8	Early maladjustment
	9	Personality disorder
	10	Prior supervision failure
B.	Clinical Items	
	1	Lack of insight (into mental disorder)
	2	Negative attitudes (toward others, institutions, social agencies, the law)
	3	Active symptoms of major mental illness
	4	Impulsivity
	5	Unresponsive to treatment
C.	Risk Management Items	
	1	Plans lack feasibility
	2	Exposure to destabilizers (e.g., weapons, substances, potential victims)
	3	Lack of personal support
	4	Noncompliance with remediation attempts
	5	Stress

Possibly the most widely used and best validated violence risk assessment tool, the HCR-20 provides practitioners a simple framework for conducting clinical violence risk assessments, exemplifying the "structured professional judgment" model of risk assessment.[149] The HCR-20 approach seems well suited for adaptation to law enforcement use and field deployment.

D. VIOLENCE RISK APPRAISAL GUIDE

The Violence Risk Appraisal Guide (VRAG) is an actuarial tool developed in 1993 by researchers working at a Canadian maximum-security hospital, and has been widely used to predict risk of violence in mentally disordered offenders with a history of

[149] "About HCR-20," accessed December 26, 2014, http://hcr-20.com/about/

violence.[150] The VRAG is comprised of 12-item scale, which includes the Hare Psychopathy checklist to develop a numeric score for assessing risk:

1. Lived with both biological parents to age 16 (except for death of parent)
Score no if offender did not live continuously with both biological parents until age 16, except if one or both parents died. In the case of parent death, score as for yes.
Yes [-2]
No [3]
This item cannot be scored due to lack of information

2. Elementary school maladjustment (up to and including Grade 8)
No problems [-1]
Slight or moderate discipline or attendance problems [2]
Severe (i.e., frequent or serious) behavior or attendance problems (e.g., truancy or disruptive behavior that persisted over several years or resulted in expulsion) [5]
This item cannot be scored due to lack of information

3. History of alcohol problems
Allot one point for each of the following: alcohol abuse in biological parent, teenage alcohol problem, adult alcohol problem, alcohol involved in a prior offense, alcohol involved in the index offense.

0 points [-1]
1 or 2 points [0]
3 points [1]
4 or 5 points [2]
This item cannot be scored due to lack of information

4. Marital status (at time of index offense)
Ever married (or lived common law in the same home for at least 6 months) [-2]
Never married [1]
This item cannot be scored due to lack of information

5. Criminal history score for convictions and charges for nonviolent offenses prior to the index offense
Score of 0 [-2]
Score of 1 or 2 [0]
Score of 3 or above [3]
This item cannot be scored due to lack of information

[150] Grant T. Harris et al., "A Multisite Comparison of Actuarial Risk Instruments for Sex Offenders," *Psychological Assessment* 15, no. 3 (2003): 413–423.

Offense	(Score) / Number	
Robbery (bank, store)	(7)	0
Robbery (purse snatching)	(3)	0
Arson and fire setting (church, house, barn)	(5)	0
Arson and fire setting (garbage can)	(1)	0
Threatening with weapon, dangerous use / pointing firearm	(3)	0
Threatening (Uttering threats)	(2)	0
Theft (Grand Larceny)	(5)	0
Mischief to public or private property over a	(5)	0
Break and enter and commit indictable offense (burglary)	(2)	0
Theft (petit larceny)	(1)	0
Mischief to public or private property under b	(1)	0
Break and enter	(1)	0
Fraud (extortion, embezzlement)	(5)	0
Fraud (forged check, impersonation)	(1)	0
Possession of a prohibited or restricted weapon	(1)	0
Procuring a person for or living on the avails of prostitution	(1)	0
Trafficking in narcotics	(1)	0
Dangerous driving, impaired driving	(1)	0
Obstructing a peace officer (including resisting arrest)	(1)	0
Causing a disturbance	(1)	0
Wearing a disguise with the intent to commit an offense	(1)	0
Indecent exposure	(2)	0

6. Failure on prior conditional release

(includes parole violation or revocation, breach of or failure to comply with recognizance or probation, bail violation, and any new charges, including the index offense, while on a conditional relea*se)*

No [0]
Yes [3]
*This item cannot be scored due t*o lack of information

7. Age at index offense
>= 39 [-5]
34-38 [-2]
28-33 [-1*]*
27 [0]
<= 26 [2]
*This item cannot be scored due t*o lack of information

8. Victim injury
Death [-2]
Hospitalized [0]
Treated and released [1]
None or slight (inc*ludes no victim) [2]*

*This item cannot be scored due t*o lack of information

9. Any female victim
(for index offense)
Yes [-1]
No (inc*ludes no victim) [1]*
*This item cannot be scored due t*o lack of information

10. Meets DSM-III criteria for any personality disorde*r*
No [-2]
Yes [3]
This item cannot be scored due to lack of information

11. Meets DSM-III criteria for schizophrenia
Yes [-3]
No [1]
This item cannot be scored due to lack of information

12. Hare Psychopathy Checklist-Revised score
(PCL-R; Hare, 1991)
<= 4 [-5]
5-9 [-3]
10-14 [-1]
15-24 [0]
25-34 [4]
>= 35 [12]

E. HARE'S PSYCHOPATHY CHECKLIST - REVISED

The Hare psychopathy checklist was developed by Canadian psychologist Robert Hare over the course of several decades beginning in the late 1970s. Revised in 1991, the Hare psychopathy checklist—revised (PCL-R) is widely used to diagnose psychopathy, measure anti-social behavior, and assess the potential for violence in forensic populations. Considered by some to be the best predictor of violent behavior, the PCL-R is a 20-item inventory of the following perceived personality traits.

HARE'S PSYCHOPATHY CHECKLIST[151]

FACET I—Interpersonal

- glib and superficial charm
- grandiose estimation of self
- pathological lying
- cunning and manipulative
- sexual promiscuity

FACET II—Affective

- shallow affect (superficial emotional responsiveness)
- callousness and lack of empathy
- lack of remorse or guilt
- failure to take responsibility for actions
- many short-term marital relationships

FACET III—Lifestyle

- need for stimulation/proneness to boredom
- parasitic lifestyle
- impulsivity
- irresponsibility
- lack of realistic long-term goals

FACET IV—Antisocial

- poor behavioral controls
- early behavior problems
- juvenile delinquency
- revocation of conditional release
- criminal versatility

F. ASSESSING IMMINENCE—DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION

With regard to assessing the imminence of violence, this study revealed little existing literature or research on the topic. Imminence is a legal burden placed on some law enforcement officers by state law. In other words, some states limit law enforcement officers and other professionals from intervening on behalf of a mentally ill person in crisis unless the risk they pose for violence is imminent. However, imminence, or the notion that violence is impending or forthcoming, is a relatively ambiguous notion. While

[151] Jennifer L. Skeem et al., "Psychopathic Personality: Bridging the Gap between Scientific Evidence and Public Policy," *Psychological Science in the Public Interest* 12, no. 3 (2011): 95–162.

some states do require an element of imminence, many do not, though the misconception that they do is widespread. According to the Treatment Advocacy Center:

> The most pervasive myth in American mental health may be the notion that imminent risk of violence or suicide is the sole permissible basis for hospital commitment. The myth persists even in states with the most progressive commitment standards and among the gatekeepers to mandatory treatment, such as law enforcement officers responding to psychiatric crisis calls who determine whether to transport an individual to a hospital for evaluation. And most tragically, it is the sort of myth that becomes true in the retelling.[152]

In considering how then to assess the imminence of violence, at least one study suggests that while static risk factors are useful in assessing future risk for violence, it is the dynamic risk factors that are most useful in gaging the imminence of violence.[153] One significant model has been developed to aid clinicians in making this assessment. The dynamic assessment of situational aggression (DASA), a seven-item structured professional judgment instrument, is intended to assist clinicians in assessing imminent, short-term risk for violence (violence that is expected to occur within 24 hours).[154]

The seven DASA risk factors, developed by incorporating risk factors from other clinical tools including the HCR-20, include:

1. Irritability
2. Impulsivity
3. Unwillingness to follow directions
4. Sensitivity to perceived provocation
5. Easily angered when requests denied
6. Negative attitudes
7. Verbal threats

---

[152] Brian Stettin et al., "Mental Health Commitment Laws: A Survey of the States," Treatment Advocacy Center, February 2014, accessed January 26, 2015, http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf.

[153] James R. P. Orgloff, and Michael Daffern, "The Dynamic Appraisal of Situational Aggression: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients," *Behavioral Sciences and the Law* #24 (2006): 799–813. DOI: 10.1002/bsl.

[154] David Canter, and Rita Zukauskiene, *Psychology and Law: Bridging the Gap* (Burlington, CA: Ashgate Publishing Company, 2008), 200.

Of these seven items, irritability, impulsivity, verbal threats, and negative attitudes were most indicative of impending aggressive behavior.[155] It bears noting that the DASA model was developed in the context of a highly controlled, inpatient hospital setting. Subsequently, in other settings and contexts there are likely other risk factors, such as evidence that the subject is planning or preparing to commit a violent act, which could be useful in gauging the imminence of violence.

G. CONCLUSION

Over the past 30 years, mental health professionals have made great strides in improving the accuracy of violence risk assessment instruments, and have identified a number of reliable risk factors for violence.[156] In particular, the MacArthur VRAS, the HRC-20, and the DASA are useful tools, components of which could be easily adapted for law enforcement use in the field.

[155] Orgloff, and Daffern, "Dynamic Appraisal," 810

[156] Conroy, and Murrie, *Forensic Assessment*, 15.

THIS PAGE INTENTIONALLY LEFT BLANK

VII. ANALYSIS AND RESULTS

> Precautions are always blamed. When successful, they are said to be unnecessary.
>
> —Benjamin Jowett

A. SELECT CLINICAL RISK FACTORS

Many of the clinical risk factors examined in Chapter VI lend themselves quite readily to field use by law enforcement; some do not. Several clinical risk factors were selected for consideration for use by law enforcement personnel in the field based on three criteria: 1) is the clinical risk factor pertinent to assessing the risk for violence, and 2) is the data sought readily available to officers in the field through normal investigative techniques, and 3) can the data sought be obtained, interpreted, and understood by law enforcement personnel, or does it require special training in psychology or other related field. The following clinical risk factors (listed in the subsections below), which were found to meet these three criteria, were selected.

(1) Gender

Men are responsible for 85–90 percent of violent behavior everywhere in the world.[157] This applies to all males, not just those afflicted with mental illness. Subsequently, gender is a significant risk factor that bears considering in any violence risk assessment. While women who suffer from mental illness do commit murder at a higher rate than women who do not suffer from mental illness,[158] analysis of all reported mass murder events in the United States in 2013 found that 96 percent were male.

(2) Age

Age is also a demonstrable risk factor for violence. The very young and the very old are less likely to commit acts of violence. Analysis of all reported mass murder events in the United States in 2013 revealed that the median age of a mass murderer was 27 and

[157] Torrey, *The Insanity Offense*, 182.

[158] Ibid.

the mean age was 33. That is not to say that the very young, and the very old never commit acts of mass murder, but such cases are statistically rare.

(3) Prior Violent Acts

Prior violence is the best predictor of future violence and should be investigated thoroughly and thoughtfully considered by officers conducting a risk assessment.

(4) Diagnosed with SMI

As stated earlier in this paper, the presence of a serious mental illness means a moderate increase in the likelihood for violence. This risk for violence increases exponentially if the person is not being treated, is not compliant with prescribed treatments, or has a co-occurring disorder such as drug or alcohol dependency.

(5) Lack of Family/Other Support

The presence of friends, family, or other care providers should be considered in risk assessment for violence. This support structure can help ensure compliance with medications or other prescribed treatment, and it can also take steps to prevent violence or call authorities when a person suffering from mental illness is in crisis or otherwise posing a risk to themselves or others.

(6) Unresponsive To or Not Compliant with Prescribed Treatment

Unresponsiveness or non-compliance with medications or treatment can result in an elevated risk for violence and should be factored into any risk assessment.

(7) Active Symptoms

In addition to a diagnosis of SMI, the manifestation of active symptoms, which include but are not limited to, severe anxiety, confused thinking, extreme mood changes, detachment from reality, delusions, hallucinations, anger, and suicidal or homicidal thoughts,[159] should be considered during an assessment for violence.

[159] "Mental Illness Symptoms—Diseases and Conditions," The Mayo Clinic, accessed January 8, 2015, http://www.mayoclinic.org/diseases-conditions/mental-illness/basics/symptoms/con-20033813

(8) Paranoid Delusions

Paranoid delusions, especially those resulting in suspicion towards others or fear that others intend to harm the person in question has been related to an increased risk for violence.

(9) Violent Thoughts

Persistent violent thoughts, thinking, or daydreaming about committing violent acts or harming others has been associated with an increased risk for violence.

(10) Command Hallucinations or Voices

The manifestation of command hallucinations or voices, especially those that instruct the person to commit acts of violence, have been associated with an increased risk for violence by both clinical and behavioral threat assessment researchers and should be explored and considered during a risk assessment.

(11) Anger and Irritability

Obviously, anger is strongly associated with violence and is a key risk factor that should be considered when conducting a violence risk assessment. Anger and irritability can also indicative of the imminence of violence as well, although irritability may be difficult for law enforcement to assess in the confines of a field contact.

(12) Recent Loss/Stressor

Both clinical and behavior threat assessment research into violence has found that a recent loss, such as the loss of a job or spouse or a similar significant stressful event, can increase the risk for violence against self or others and should be considered when conducting a risk assessment.

(13) Access to Weapons

Access to weapons alone may not indicate an increased risk for violence; however the presence of weapons, especially firearms, should be taken into consideration by investigating officers. Officers can choose to temporarily seize firearms or other weapons for short-term safekeeping and return them once the person is no longer in crisis.

(14) Substance Abuse

The abuse of drugs or alcohol, especially if co-occurring with a serious mental illness, has been shown to increase the risk for violence among persons suffering from SMI.

Three significant clinical and criminological risk factors were not selected for law enforcement use in the field. These risk factors are psychopathy (as measured by Hare's Psychopathy Checklist), neighborhood context, and history of adverse childhood experiences (ACE), such as child abuse and parental substance abuse. Though all three of these factors are associated with an increased risk for violence, these risk factors would arguably require specialized training, be difficult for officers to accurately assess, or require too much time for officers to assess in the field.

B. SELECT BEHAVIORAL THREAT ASSESSMENT AND OTHER RISK FACTORS

The following are selected risk factors from BTA, or represent good investigative practices, and should be considered during a risk assessment (some of these BTA risk factors, such as threatened violence, are also clinical risk factors as well):

(1) Prior Suicide Attempts

Prior suicide attempts may be a good indicator of current or future suicidal ideation, and they should be considered when conducting a risk assessment.

(2) Criminal History and Local Arrest Record

Criminal history and local arrest or contact records should always be examined when assessing risk for violence as past behavior is a strong indicator of future behavior.

(3) History of Weapons Offenses

Prior weapons offenses, including weapons offenses that do not necessarily involve violence (e.g., discharging a firearm, unlawfully carrying a concealed weapon, possession of a dangerous weapon) might be indicative of future violence and should be considered during a risk assessment.

(4) Prior Involuntary Civil Commitment

Prior involuntary civil commitments may be indicative of previous danger to self, or others, and should be considered during any subsequent risk assessment.

(5) Fascination with Weapons, Murder, or Murderers

Behavioral threat assessment research conducted by Fein and Vossekuil has indicated that a fascination with weapons, murder or violence, assassins, or other infamous murderers

(6) Planned, Threatened, or Attempted Violent Act

Threatened or attempted violence should, quite obviously, factor in to any risk assessment. Officers conducting a violence risk assessment must also take time to search for signs that violence has been threatened or is being planned. This might include verbalized threats or plans, written threats or plans, electronic files, email, or postings on social media or other medium. Indicators such as planned or threatened violence are also key indicators for assessing the imminence of violence.

(7) Impulsive and/or Unwilling to Comply with Directions

Impulsivity and refusal to comply with orders or directions has been linked to both violence as well as the possible imminence of violence and should be considered when conducting a risk assessment.

(8) Actual Violence

In cases where the subject has committed a violent act against his or herself, officers, or other persons at the scene, there can be no question of the dangerousness posed by that person and action must be taken to protect the person and others.

C. ANALYSIS OF SAMPLE CASES BY APPLYING A CLINICAL RISK ASSESSMENT FRAME

As demonstrated in Chapter VI, mental health care practitioners and researchers have developed several tools that have been demonstrated to be quite accurate in assessing the risk for violence among the mentally ill. A retrospective examination of the

previous case samples discussed in Chapter IV will now be conducted in light of these clinical and BTA risk factors beginning with completed attacks, followed by the thwarted attacks.

1. Washington Navy Yard

Aaron Alexis, the Washington Navy Yard (WNY) shooter, met the demographic risk factors for violence, since he was a male under the age of 50. Alexis also met many of the historical risk factors, such as a criminal history, including two arrests for offenses committed with a firearm, and a history of substance abuse (alcohol). Alexis's criminal history information would have been readily available to officers called to make an assessment. Alexis manifested several clinical risk factors, as he was obviously suffering from a serious mental illness (paranoid and delusional). Alexis's behavior was so strange, in fact, that it prompted two separate calls to police from parties concerned that he might hurt someone. Several significant contextual risk factors were also readily discernable, given that Alexis was alone, away from home, and lacked family or other support systems. Furthermore, Alexis had both a fascination with and access to firearms, as demonstrated by his involvement in two previous shooting incidents. Finally, Alexis demonstrated several "imminent" risk factors for violence associated with his delusional paranoia and extreme anxiety. All of this information was either readily available to police or could have been obtained through a cursory investigation. Unfortunately, the officers on scene either failed to recognize the warning signs or were not receptive to them. While a different course of police action during their contact with Alexis on August 6 and 7, 2013 may not have prevented the subsequent deadly shooting at the Washington Navy Yard, it is reasonable to conclude that had police initiated an involuntary commitment, or at the very least notified Alexis's family or employer, Alexis likely would have received badly needed mental health care, and the chain of events leading to the shooting might have been disrupted.

2. Isla Vista, California

Elliot Rodger, the University of California Santa Barbara (UCSB) shooter, met the demographic risk factors of age and gender. It has also been argued that Rodger,

while not officially diagnosed with any serious mental illness, did in fact present clear symptoms of both psychopathy and psychosis, including paranoid delusions.[160] Rodger had a record of prior contact with law enforcement, including an incident in which he attempted to push two women off of a balcony. In addition, Rodger had posted both suicidal and homicidal thoughts on social media sites. Moreover, Rodger was in fact planning a violent attack, and he had access to weapons. The failure of law enforcement officers to seriously consider the threat posed by Rodger is now well known. Had officers conducted a more comprehensive risk assessment, it is likely Rodger's plan would have come to light and his attack on UCSB could have been thwarted. Santa Barbara sheriff's deputies cited California Penal Code 5150 and its "imminence" clause as one reason for not doing more to stop Elliot Rodgers. This code, which regulates the detention of a "mentally disordered person" for treatment, is similar in content to many other state laws and more liberal than some. California Penal Code 5150 states in part:

> When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. …When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder. For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by

[160] Peter Langman, "Elliot Rodger: A Psychotic Psychopath?" *Psychology Today*, May 28, 2014, accessed January 8, 2015, http://www.psychologytoday.com/blog/keeping-kids-safe/201405/elliot-rodger-psychotic-psychopath

> the person subject to a determination described in subdivision (a) or anyone designated by that person.[161]

As can be seen from California Penal Code 5150, there is no requirement that the dangerousness posed by the mentally ill person be immediate or imminent, as is often assumed. Had deputies investigated further, they would have undoubtedly uncovered evidence of Rodger's impending attack (Rodgers later wrote in his "Day of Retribution" manifesto that when the deputies appeared at his house, he feared they would search his room and uncover his plot, writing "I thought it was all over"[162]). The lack of intervention by Santa Barbara County Sheriff's deputies called to Elliot Rodger's house was not so much out of obedience to the law, which prevented them from taking action but a failure in officer discretion—a failure to recognize warning signs, or to investigate the facts and circumstances sufficiently to either confirm, or rule out the presence of dangerousness. Worse, Santa Barbara County has a specialized unit staffed by mental health care professionals, known as the Crisis and Recovery Emergency Services (CARES), which responds to assist persons in crisis. Deputies did not call this team to assist with an assessment, however, because they were not receptive to the initial warning signs, having failed to ascertain the imminent threat that Rodgers actually presented.

3. DeAnza College

As a young male, Al DeGuzman fit the demographic risk profile. DeGuzman also met clinical risk factors, as a troubled young man who suffered from an untreated serious mental illness in the form of major depression. In addition, DeGuzman struggled with suicidal ideations from adolescence and ultimately committed suicide while incarcerated, a manifestation of a significant historical risk factor. Moreover, DeGuzman manifested contextual risk factors, displaying a fascination with, and access to weapons—both firearms and improvised explosive devices. Not only that, but he was also fascinated by

---

[161] California law, section 5150, Regs Today, accessed August 25, 2014, http://ca regstoday.com/law/wic/ca regstoday.com/laws/wic/calaw-wic_DIVISION5_PART1_CHAPTER2.aspx

[162] Adolfo Flores, Richard Winter, and Kate Mather, "Deputies Didn't Know Elliot Rodger had Firearms before Deadly Rampage," *LA Times*, May 30, 2014, accessed June 12, 2014, http://www.latimes.com/local/lanow/la-me-ln-elliot-rodger-guns-sheriff20140530-story.html

the Columbine killers and engaged in violent thoughts and fantasies that led him to plan a murderous attack on De Anza College. Finally, DeGuzman demonstrated imminent risk factors in his violent thoughts and elaborate plans to attack DeAnza College. Fortunately for the students of De Anza College, the San Jose police officers called to Longs Drug Store, where the photos of DeGuzman posing with his weapons had been developed, were receptive to the initial warning signs and conducted the necessary investigation to reveal the scope of the threat.

4. Gardnerville, Nevada

As a male in his twenties, Michael Tom also met the demographic risk factors. Tom had significant historical and clinical risk factors, with several documented episodes of domestic violence, and a diagnosis of paranoid schizophrenia. Not only had Tom had been involuntarily committed for mental health treatment on at least two occasions he also suffered from paranoid delusions and heard command voices telling him to kill his neighbors. Contextually, Tom had both access to and an intense fascination with weapons, and he kept an AR-15 rifle with him in his home at all times of the day and night. In assessing the imminence of violence, Tom met all of the risk factors and was often angry, regularly experienced violent ideations, and often threatened to harm those around him. Responding officers recognized the warning signs, were receptive to the warning signs, and conducted a thorough investigation, which resulted in the removal of firearms from the residence and treatment for Tom.

D. RESULTS OF ANALYSIS

The WNY and Isla Vista cases are illustrative for several reasons. First, they reveal the flawed “yes/no” dichotomous approach typically used by officers in the field when assessing dangerousness. Second, they reveal a critical lack of unawareness of the warning signs and risk factors for violence, which demonstrates that law enforcement officers desperately need a tool to assist them with conducting more comprehensive risk assessments.

In addition to proving that law enforcement can prevent acts of mass murder, the DeAnza College and Gardnerville, Nevada cases are demonstrative of two more things

critical in any law enforcement risk assessment of a person with mental illness. First, law enforcement officers must be willing to take the time necessary to conduct a comprehensive risk assessment. Second, law enforcement officers must be able to see beyond the surface and recognize the potential for harm. In other words, there must be a high level of receptivity to the warning signs revealed as a result of an investigation. This inquisitiveness and receptivity was markedly absent in the law enforcement contacts leading up to both the WNY and Isla Vista shootings.

Returning to Dahl's *Theory of Preventive Action*, in order to prevent a surprise attack, there must be precise, tactical level warning signs, and there must be a high level of receptivity toward the warning signs on the part of those in a position to intervene and to act in order to interrupt the pathway to violence.[163] In the first two cases, there was a failure of receptivity to the information that was available, a failure to consider what was possible, and failure to investigate a little further to uncover those tactical level warning signs. In the end, these officers failed in their duty to conduct a risk assessment—to conceptualize the potential future dangerousness of the individual standing before them. By contrast, officers involved in the DeGuzman case demonstrated a high degree of receptivity to the initial warning signs, which prompted them to look further into the situation.

A re-examination of the sample cases in light of both BTA and clinical risk assessment models demonstrates that in the cases where the perpetrator completed an attack there were clear warning signs that law enforcement officers, if properly trained and equipped, could had recognized and acted to interrupt the chain of events. Data from the prologue case (Carson City IHOP shooter Eduardo Sencion) has been included for the purpose of comparison and analysis (see Table 5).

[163] Dahl, *Intelligence and Surprise Attack*, 23.

Table 5. Analysis of Perpetrators and Risk Factors

	Risk Factors	Completed Attack			Pre-Empted Attack	
		Alexis	Rodgers	Sencion	Deguz	Tom
Demographic Factors	Gender - Male	✓	✓	✓	✓	✓
	Age - 15 - 50 Years of Age	✓	✓	✓	✓	✓
Historical Factors	Prior Violent Acts	✓	✓			✓
	History of Substance Abuse	✓	✓			✓
	Prior Suicide Thoughts or Attempts			✓	✓	
	Use of Weapons in Any Crime	✓				✓
	Arrest Record	✓				✓
	Prior Involutary Commitment			✓		✓
Clinical Factors	Diagnosed or Suspected Serious Mental Illness	✓	✓	✓	✓	✓
	Unresponsive to / Not Compliant with Treatment	✓		✓		✓
	Active Symptoms	✓	✓	✓	✓	✓
	Psychopathy	✓	✓			✓
	Paranoid Delusions	✓	✓	✓	✓	✓
	Violent Thoughts	✓	✓	✓	✓	✓
	Violent Hallucinations / Command Voices	✓		✓		✓
	Anger	✓	✓			✓
Other Risk Factors	Lack of Family Support	✓				✓
	Recent Loss / Other Stressor		✓			
	Access to Weapons	✓	✓	✓	✓	✓
	Fascination with Weapons	✓	✓	✓	✓	✓
	Current Substance Abuse					✓
	Fascination with Murder or Murderers		✓	✓	✓	✓
	Verbalized / Written Threats	✓	✓	✓	✓	✓
	Attempted / Planning Violent Act	✓	✓		✓	

As Table 5 illustrates, the perpetrators in each of the four cases manifested numerous risk factors, many of which were, or should have been, apparent to officers and sufficient to warrant further investigation and intervention. In re-examining the sample cases, it becomes clear that a more robust, comprehensive risk assessment can and should be adapted from clinical and behavioral threat assessment models for use by law enforcement in the field.

THIS PAGE INTENTIONALLY LEFT BLANK

VIII. RECOMMENDATIONS AND CONCLUSION

It is far better to foresee even without certainty than not to foresee at all.

—Henri Poincare, *The Foundations of Science*, 1913

A. SUMMARY OF RESEARCH

A growing body of evidence now suggests that a particular subgroup of persons with serious mental illness is significantly more dangerous than person in the general population, and law enforcement officers are often called upon to fulfill the role of gatekeeper—deciding if a person with mental illness should enter the mental health care system, or the criminal justice system.[164] These factors place a significant public safety obligation upon law enforcement officers and a duty to ensure that mentally ill persons receive proper care and treatment for their condition.

Society clearly expects law enforcement officers to be adequately equipped to address the needs of the mentally ill and to take reasonable steps to ensure public safety. This expectation may be inferred from the fact that citizens routinely call upon law enforcement for assistance with mentally ill persons and from the simple fact that there is often no other resource that can be called upon to respond at such times. Considering law enforcement's ever-increasing volume of calls involving persons with mental illness, its duty to protect the safety and welfare of the community and its parens patriae obligation to safeguard those who are unable to care for themselves, law enforcement officers must be better equipped to fulfill these essential roles.

This research asserts that in spite of this increasing responsibility and role with regards to the mentally ill, law enforcement personnel are inadequately trained and equipped to conduct even rudimentary violence risk assessments. Most startling, this research reveals an apparent lack of receptivity to warning sings among many LEOs. As illustrated by the Aaron Alexis and Elliot Rodger cases, law enforcement officers have been called upon to assess the risk of mentally ill persons and have either failed to

[164] Lamb, Weinberger, and DeCuir, Jr., "The Police and Mental Health."

identify significant risk factors, been unreceptive to risk factors or both—with tragic results. This research further asserts that law enforcement can, through the application of clinical risk factors, identify someone at risk for violence and act to interrupt the chain of events leading to violence. Moreover, the Al DeGuzman and Michael Tom cases demonstrate that when officers identify significant risk factors for violence, are receptive to those risk factors, and take action to intervene, violence can be averted.

In addition to missing or ignoring warning signs and other indicators of possible dangerousness, this research has identified three significant deficiencies with how many law enforcement officers currently conduct, or fail to conduct, violence risk assessments of mentally ill persons. First, LEOs receive little training on how to conduct such risk assessments. Second, LEOs have a framework or guide for conducting comprehensive risk assessments. Finally, many LEOs view risk as a dichotomous, "yes or no" proposition—either the person poses a risk for violence or they do not. In reality, the risk for violence should be considered along a continuum of risk and assessed accordingly.

Psychiatrists and other clinicians have grappled with accurately assessing the "dangerousness" of certain subjects for years, providing rich theoretical frameworks that should serve as the foundation for law enforcement risk assessments. As the result of this continuous research, the risk paradigm has shifted from a "yes/no" prediction of dangerousness to an evaluation of risk along a continuum from a lower risk of violence, to a higher risk of violence.[165] Similarly, law enforcement must also begin gauging risk for violence along a continuum and not simply attempt a "yes/no" decision regarding dangerousness and the likelihood for violence.

Law enforcement officers have an obligation to conduct fact based, evidence driven assessments of dangerousness and to use the same investigative techniques they regularly employ in more traditional criminal investigations. To achieve this goal, law enforcement officers require an empirical, comprehensive, yet simple violence risk assessment tool that will help them to identify warning indicators that a person with mental illness is on pathway to violence. This violence risk assessment instrument should

[165] Conroy, and Murrie, *Forensic Assessment of Violence Risk*, 7.

be based on the decades of existing clinical research, data and established risk factors. In addition, it should be used to address the more nuanced components of violence, such as the imminence of violence, the potential severity of violence, the likelihood of weapons use, and other factors or conditions most conducive to violence in a particular case.[166]

B. A FIELD RISK ASSESSMENT GUIDE FOR LAW ENFORCEMENT

Given the obvious differences in training and experience between clinicians and law enforcement officers, the setting where the assessments must occur (field versus office, hospital, or clinical environment), and the time constraints often present in a law enforcement contact,[167] it is important for any law enforcement risk assessment tool to be adapted from the clinical format and both streamlined and simplified for field use by non-clinicians. As reported in this thesis, law enforcement officers are regularly called upon to make violence risk assessments in the field that can affect both the liberty interests of mentally ill persons, as well as the safety of the community officers serve. Providing LEOs with a field risk assessment guide adapted from clinical frameworks, which have been in use for years and validated in clinical trials, will inevitably assist them in making better decisions when dealing with mentally ill persons.

As the DeAnza College and Gardnerville, Nevada thwarted attacks indicate, many law enforcement officers, using nothing more than their limited training and significant experience, demonstrate some ability to identify mentally ill persons who pose a risk for violence. Sadly, the WNY and Isla Vista, California cases demonstrate the need for additional training to improve officer recognition of warning signs and increased receptivity to warning signs. Use of a structured tool for assessing risk would improve officer risk assessments, and it could have potentially changed the outcome in the WNY and Isla Vista cases.

By examining both traditional law enforcement and clinical approaches to risk assessment, this research has identified several critical risk factors for violence, which

---

[166] Ibid.

[167] The U.S. Supreme Court ruled in the1968 landmark case Terry v. Ohio, that police are limited in how long they may detain a subject to a reasonable amount of time to conduct an investigation, and they must be able articulate the reasons for any such temporary detention.

can be constructed in such a way as to provide law enforcement personnel with a reliable framework for assessing the potential dangerousness of a mentally ill person contacted in the field, as well as the imminence of potential violence. In broad categories, these risk factors consist of personal or demographic risk factors, historical risk factors, clinical risk factors, and contextual risk factors and should be developed into a template or guide for public safety field use (see Table 6).

Table 6. The Field Risk Assessment Guide

PUBLIC SAFETY
FIELD RISK ASSESSMENT GUIDE

Date:_____ Time:_____ Location:_____

Subject name:_____DOB:_____Phone:_____

Address:_____

Demographic Risk Factors	1. Gender – male	□ yes	□ no	□ unk
	2. Age – Between 15 and 50 years of age	□ yes	□ no	□ unk
Historical Risk Factors	3. History of violence and/or suicide attempt	□ yes	□ no	□ unk
	4. Criminal history	□ yes	□ no	□ unk
	5. History of substance abuse (RX, illegal drugs, or alcohol)	□ yes	□ no	□ unk
	6. Prior involuntary civil commitment	□ yes	□ no	□ unk
	7. Prior weapons offense of any kind	□ yes	□ no	□ unk
Clinical Risk Factors	8. Diagnosed with mental illness (list_____)	□ yes	□ no	□ unk
	9. Unresponsive to, or not compliant with treatment	□ yes	□ no	□ unk
	10. Exhibiting active symptoms of mental illness, and/or irrationality	□ yes	□ no	□ unk
	11. Exhibiting symptoms of paranoia, and/or delusional	□ yes	□ no	□ unk
Contextual Risk Factors	12. Lack of family, or other structured support in life	□ yes	□ no	□ unk
	13. Recent loss, or other major stressor in life	□ yes	□ no	□ unk
	14. Access to, or owns weapons	□ yes	□ no	□ unk
	15. Fixation, or fascination with weapons, murder, or murderers	□ yes	□ no	□ unk
Imminence Risk Factors	16. Obvious signs of anger and/or irritability	□ yes	□ no	□ unk
	17. Violent thoughts, and/or command voices	□ yes	□ no	□ unk
	18. Planning, threatened, or attempted violence	□ yes	□ no	□ unk
	19. Impulsive, and/or unwilling to comply with directions	□ yes	□ no	□ unk
	20. Actually committed a violent act against officers or others	□ yes	□ no	□ unk

Officer/RP Observations

_____

_____

_____

Total score (add up number of boxes checked "yes"):_____

Disposition

□ No action required □ Subject issued citation#_____□ Subject Arrested for _____

□ Referred for follow-up to:_____ □ Involuntary Civil Commitment Initiated

Officer:_____Date:_____Time:_____ Case#: _____

Law enforcement officers tasked with assessing a mentally ill person for dangerousness are acting in good faith, and they should be expected to err on the side of

caution—to intervene and interrupt the chain of events that could lead to violence; to make reasonable inferences based on an objective, articulable facts, rather than miss, or, worse, ignore critical warning signs.

C. IMPLEMENTATION AND NEXT STEPS

The field risk assessment guide (FRAG) proposed in this paper could serve as a template for law enforcement organizations nationally to improve officer conducted assessments of dangerousness and be deployed for use in the field immediately. Use of the FRAG would greatly improve law enforcement's response to persons with mental illness by increasing the likelihood of treatment of mentally ill persons, reducing the incidence of violence among persons with mental illness, and, perhaps, even pre-empting some mass murder events. The FRAG is not intended to limit officer discretion or mandate a particular outcome, such as involuntary civil commitment, but is simply designed to provide a structured guide by which an officer can assess the dangerousness posed by a particular individual. In addition, FRAG is not limited to use in cases where mental illness is suspected, as mental illness is only one factor in assessing the risk for violence.

Widespread adoption of the FRAG or similar tool designed for field use could be accomplished quickly, and with little cost to law enforcement organizations.[168] Ideally, training on the use of the FRAG could be provided to new recruits at police training academies in a four to eight hour block of training, in Field Training Officer (FTO) programs over the course of several weeks of on-the-job training, or it could be integrated into the week-long CIT course currently provided to many law enforcement officers across the country, thereby filling a vital missing component of current CIT training. In-service training of veteran officers on use of the FRAG would be relatively simple, given that it provides a framework to guide officers through a task that they are already doing on a regular basis, possibly even simplifying the process through consistency.

[168] While there is little anticipated cost to law enforcement organizations, mental health care providers should anticipate a modest increase in involuntary commitments and referrals for treatment.

When considering the problem of mental illness, violence, and strategies for enhancing public safety, stakeholders can be broken into three primary groups: 1) the public at large, which is increasingly concerned about what appears to be an increase in acts of violence and mass murder perpetrated by the mentally ill; 2) law enforcement personnel, who are tasked with pursuing their public safety mission while recognizing the rights and treatment needs of persons suffering from mental illness; and 3) clinicians, mental health care professionals, and those who advocate on behalf of the mentally ill and who are primarily concerned with protecting the rights of persons with mental illness, ensuring that they receive effective treatment for their illnesses. Changing current public safety practices by implementing the FRAG will ideally involve the support of each of these stakeholders, especially law enforcement executives and forensic mental health care partners. Through necessity, law enforcement has been forming a closer partnership with forensic mental health care providers over the past few decades. Successful implementation of the FRAG would benefit from the support of these partners.

The FRAG does not recommend actions or outcomes. Rather, it seeks to aid officers in recognizing warning signs that a mentally ill person could be on the pathway to violence. Enforcement options are left to the discretion of the officers on scene and are typically controlled by law and policy, varying state-by-state and agency-by-agency. While this means the FRAG should not be in conflict with any state law or agency policy regarding interaction with mentally ill persons, agencies seeking to adopt this field risk assessment guide should seek input from their city, county, or state attorneys to ensure that this risk assessment instrument is both compatible and in compliance with individual state laws governing involuntary commitments and the treatment of mentally ill persons.

Finally, this research was designed to narrowly focus on and address the pressing public safety problem of mass murder and extreme violence committed by persons with mental illness. By recommending a structured approach to law enforcement risk assessments, it is suggested that some violence can be prevented, and some mentally ill persons can receive the treatment so desperately needed. Looking to the future, many other challenges within the sphere of mental illness and public policy will likely remain

unabated, requiring the continued attention of scholars, researchers, clinicians, public safety personnel, policy analysts, and politicians.

D. AREAS FOR FURTHER RESEARCH

This thesis builds upon Chief Michael Biasotti's research,[169] which explored the impact persons with mental illness have on law enforcement resources. There remain many significant issues and public policy challenges regarding mental illness that warrant further research. First, there remain two areas of future research relating specifically to the field risk assessment guide. One is that of validating the field risk assessment guide's efficacy in reducing violence and increase treatment of persons with mental illness. Validating the FRAG in general, as well as the component risk factors, is critical to demonstrating its effectiveness. Validation could be accomplished through future research that measures violence locally where the FRAG has been deployed and perhaps by measuring mass murders nationally if deployed broadly enough to determine if enhanced risk assessments have in fact lowered the incidence of violence committed by persons with mental illness. The second area of future research relating to the FRAG is that of establishing metrics or values for the component risk factors in order to identify which factors are most indicative of violence and to prioritize the risk factors accordingly.

One problem enhanced risk assessments do nothing to solve is that of the acute lack of bed space for those most seriously affected by mental illness and those who have been deemed most dangerous. The work of Biasotti and others has documented these problems sufficiently; however there remain few options and a lack of will, both publicly and politically (not to mention the lack of funding in most communities), to build the facilities necessary to house the severest cases.

The lack of enforcement and treatment options for public safety personnel confronted with a mentally ill person in crisis is another ongoing challenge. Even when dangerousness and the risk for violence are identified in a person with mental illness, law enforcement officers have few options for addressing the situation. Options for

[169] Biasotti, "Management of the Severely Mentally Ill and its Effects on Homeland Security."

addressing a mentally ill person in crisis typically include arrest or citation where a crime has occurred; the initiation of involuntary commitment proceedings, transport to a hospital for treatment, a referral for treatment at a later date; or no action whatsoever, when the mentally ill person has not committed a crime. Most law enforcement officers and clinicians know from experience that involuntary commitment is a short-term solution, which alone typically will not solve or eliminate dangerousness altogether. Persons committed to psychiatric hospitals on an involuntary basis often receive treatment that is limited in scope, are often released precipitately, and are not monitored effectively, if at all, once released to ensure compliance with prescribed anti-psychotic medications or other therapies.[170] Subsequently, expanding compulsory or assisted outpatient treatment, mental health courts, or other programs for mentally ill persons that are deemed dangerous poses an ongoing challenge and an area meriting further research.

Another significant public policy challenge warranting further research is that of balancing the constitutional rights of persons with mental illness with the public safety goal of keeping firearms out of the hands of mentally ill persons who are not competent to possess them. This issue is both complex and intractable and merits much thought and consideration.

[170] APA Panel of Experts, "Gun Violence: Prediction, Prevention, and Policy," American Psychological Association, 2013), http://www.apa.org/pubs/info/reports/gun-violence-prevention.aspx, 22.

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX A. U.S. MASS MURDERS, 2013

name	date	victims	location	motive	mental illness	gender	race	age
suspect unidentified	12/1/13	4	Topeka, KS	unknown	unk			
David Bennett jr.	11/23/13	4	Parsons, KS	rape	yes - prior arrest for suicidal/homicida	m	black	22
suspect unidentified	11/23/13	4	Tulsa, OK	drugs	unk			
suspect unidentified	11/7/13	4	Jacksonville, FL	drugs	unk			
Bryan Sweatt	10/29/13	5+1	Callison, SC	domestic	no	m	white	27
Charles Brownlow jr.	10/28/13	5	Terrell, TX	domestic	yes - long history of unaddressed men	m	black	36
Michael Guzzo	10/26/13	4+1	Phoenix, AZ	active shooter - nei	yes - history of depression and alcohol	m	white	56
Mingdong Chen	10/26/13	5	New York, NY	domestic	yes - found unfit to stand trial	m	asian	26
suspect unidentified	10/9/13	4	Paris, TX	unk	unk			
Guadalupe Ronquillo-Ovalle	9/20/13	4+1	Rice, TX	domestic	unk	f	hispanic	33
Aaron Alexis	9/16/13	12 + 1	Washington, DC	active shooter-pub	yes - untreated paranoia / schizophrer	m	black	34
Jacob Allen Bennett	9/11/13	4	Crab Orchard, TN	robbery	unk - long criminal history	m	white	26
Daniel Green	8/14/13	4	oklahoma city, OK	domestic	yes - schizophrenic	m	white	40
Erbie Bowser	8/7/13	4	Dallas, TX	domestic	unk	m	black	44
Pedro Alberto Vargas	7/26/13	6+1	Hialeah, FL	active shooter - pul	yes -suspected by family members	m	hispanic	42
Sydney Muller	7/26/13	4	Clarksburg, WV	drugs	yes - history of mental illness, combat	m	white	27
John Zawahri	6/7/13	4+1	Santa Monica, CA	active shooter - sch	yes	m	arab	23
Jeremiah Bean	5/13/14	5	Fernley, NV	robbery	yes	m	unk	25
Samuel Sallee	5/11/13	4	Waynesville, IN	drugs	yes with history of drug abuse	m	white	55
Derrek Twardoski	5/10/13	4	Percy, Ill	arson	yes	m	white	33
Kyle Flack	4/28/13	4	Ottawa, KS	domestic	yes with history of drug abuse	m	white	27
Rick Odell Smith	4/24/13	5+1	Manchester, IL	domestic	unk	m	white	43
Dennis Clark III	4/22/13	4+1	Federal Way, WA	domestic	no	m	black	27
Derrick Brantley & Deshanon Hayv	4/18/13	4	Akron, OH	robbery	no	m	black	21/21
Dzhokhar & Tamerlan Tsarnaev	4/15/13	4+1	Boston, MA	terrorism	no	m	white	21/28
Kurt Myers	3/13/13	4+1	Herkemer, NY	active shooter - pul	unk - none diagnosed	m	white	64
Nehemiah Griego	1/19/13	5	Albuquerque, NM	domestic	yes - diagnosed in jail	m	white	15
Cedric & James Poore	1/7/13	4	Tulsa, OK	robbery	no	m	black	32/39

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX B. DSM-IV DEFINITION OF SERIOUS MENTAL ILLNESS AND CODES BY DISORDER

"Serious Mental Illness" (Adult with a Serious Mental Illness) means an individual 18 years of age or older who meets the following criteria:[185]

A. Currently or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet criteria specified within DSM-IV with the exception of "V" codes, substance use disorders, and developmental disorders, unless they co-occur with another diagnosable serious mental illness;

and

B. Has at least **(a)** moderate impairment in at least four, **(b)** severe impairment in two or **(c)** extreme impairment in one of the following areas:
   1. **Feeling, Mood, and Affect:** Uncontrolled emotion is clearly disruptive in its effects on other aspects of a person's life. Marked change in mood. Depression and/or anxiety incapacitates person. Emotional responses are inappropriate to the situation.
   2. **Thinking:** Severe impairment in concentration, persistence, and pace. Frequent or consistent interference with daily life due to impaired thinking. Presence of delusions and/or hallucinations. Frequent substitution of fantasy for reality.
   3. **Family:** Disruption of family relationships. Family does not function as a unit and experiences frequent turbulence. Relationships that exist are psychologically devastating.
   4. **Interpersonal:** Severe inability to establish or maintain a personal social support system. Lacks close friends or group affiliations. Socially isolated.
   5. **Role Performance:** Frequent disruption of role performance and individual is unable to meet usual expectations. Unable to obtain or maintain employment and/or conduct daily living chores such as care of immediate living environment.
   6. **Socio-legal:** Inability to maintain conduct within the limits prescribed by law, rules, and strong mores. Disregard for safety of others. Destructive to property. Involvement with law enforcement.
   7. **Self Care/Basic Needs:** Disruption in the ability to provide for his/her own needs such as food, clothing, shelter, and transportation. Assistance required in obtaining housing, food and/or clothing. Unable to maintain hygiene, diet, clothing, and prepare food.

or

C. Has a duration of illness of at least one year and (a) at least moderate impairment in two, or (b) severe impairment in one of the following areas:
   1. **Feeling, Mood, and Affect:** Uncontrolled emotion is clearly disruptive in its effects on other aspects of a person's life. Marked change in mood. Depression

[185] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Arlington, VA: American Psychiatric Publishing, 2000). All material in Appendix B is from this source.

and/or anxiety incapacitates person. Emotional responses are inappropriate to the situation.

2. **Thinking:** Severe impairment in concentration, persistence and pace. Frequent or consistent interference with daily life due to impaired thinking. Presence of delusions and/or hallucinations. Frequent substitution of fantasy for reality.
3. **Family:** Disruption of family relationships. Family does not function as a unit and experiences frequent turbulence. Relationships that exist are psychologically devastating.
4. **Interpersonal:** Severe inability to establish or maintain a personal social support system. Lacks close friends or group affiliations. Socially isolated.
5. **Role Performance:** Frequent disruption of role performance and individual is unable to meet usual expectations. Unable to obtain or maintain employment and/or conduct daily living chores such as, care of immediate living environment.
6. **Socio-legal:** Inability to maintain conduct within the limits prescribed by law, rules, and strong mores. Disregard for safety of others. Destructive to property. Involvement with law enforcement.
7. **Self Care/Basic Needs:** Disruption in the ability to provide for his/her own needs such as food, clothing, shelter and transportation. Assistance required in obtaining housing, food and/or clothing. Unable to maintain hygiene, diet, clothing, and prepare food.

DSM-IV DIAGNOSIS CODES

Please note that these codes reflect the organizational structure specifically of the DSM-IV, not the DSM-IV-TR, which is the current version as of this writing.

Code	Disorder	Category
308.3	Acute Stress Disorder	Anxiety Disorders
309.9	Adjustment Disorder Unspecified	Adjustment Disorders
309.24	Adjustment Disorder with Anxiety	Adjustment Disorders
309.0	Adjustment Disorder with Depressed Mood	Adjustment Disorders
309.3	Adjustment Disorder with Disturbance of Conduct	Adjustment Disorders
309.28	Adjustment Disorder with Mixed Anxiety and Depressed Mood	Adjustment Disorders
309.4	Adjustment Disorder with Mixed Disturbance of Emotions and Conduct	Adjustment Disorders
300.22	Agoraphobia without History of Panic Disorder	Anxiety Disorders
307.1	Anorexia Nervosa	Eating Disorders
301.7	Antisocial Personality Disorder	Personality Disorders
293.89	Anxiety Disorder Due to Medical Condition	Anxiety Disorders

Code	Disorder	Category
300	Anxiety Disorder, NOS	Anxiety Disorders
301.82	Avoidant Personality Disorder	Personality Disorders
296.8	Bipolar Disorder NOS	Mood Disorders
296.56	Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission	Mood Disorders
296.55	Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission	Mood Disorders
296.51	Bipolar I Disorder, Most Recent Episode Depressed, Mild	Mood Disorders
296.52	Bipolar I Disorder, Most Recent Episode Depressed, Moderate	Mood Disorders
296.54	Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features	Mood Disorders
296.53	Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features	Mood Disorders
296.50	Bipolar I Disorder, Most Recent Episode Depressed, Unspecified	Mood Disorders
296.46	Bipolar I Disorder, Most Recent Episode Manic, In Full Remission	Mood Disorders
296.45	Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission	Mood Disorders
296.41	Bipolar I Disorder, Most Recent Episode Manic, Mild	Mood Disorders
296.42	Bipolar I Disorder, Most Recent Episode Manic, Moderate	Mood Disorders
296.44	Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features	Mood Disorders
296.43	Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic	Mood Disorders

Code	Disorder	Category
	Features	
296.40	Bipolar I Disorder, Most Recent Episode Manic, Unspecified	Mood Disorders
296.66	Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission	Mood Disorders
296.65	Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission	Mood Disorders
296.61	Bipolar I Disorder, Most Recent Episode Mixed, Mild	Mood Disorders
296.62	Bipolar I Disorder, Most Recent Episode Mixed, Moderate	Mood Disorders
296.64	Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features	Mood Disorders
296.63	Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features	Mood Disorders
296.60	Bipolar I Disorder, Most Recent Episode Mixed, Unspecified	Mood Disorders
296.7	Bipolar I Disorder, Most Recent Episode Unspecified	Mood Disorders
296.40	Bipolar I Disorder, Most Recent Episode Hypomanic	Mood Disorders
296.06	Bipolar I Disorder, Single Manic Episode, In Full Remission	Mood Disorders
296.05	Bipolar I Disorder, Single Manic Episode, In Partial Remission	Mood Disorders
296.01	Bipolar I Disorder, Single Manic Episode, Mild	Mood Disorders
296.02	Bipolar I Disorder, Single Manic Episode, Moderate	Mood Disorders
296.04	Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features	Mood Disorders
296.03	Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features	Mood Disorders
296.00	Bipolar I Disorder, Single Manic	Mood Disorders

Code	Disorder	Category
	Episode, Unspecified	
296.89	Bipolar II Disorder	Mood Disorders
300.7	Body Dysmorphic Disorder	Somatoform Disorders
301.83	Borderline Personality Disorder	Personality Disorders
780.59	Breathing-Related Sleep Disorder	Sleep Disorders, Dyssomnias
298.8	Brief Psychotic Disorder	Psychotic Disorders
307.51	Bulimia Nervosa	Eating Disorders
307.45	Circadian Rhythm Sleep Disorder	Sleep Disorders, Dyssomnias
300.11	Conversion Disorder	Somatoform Disorders
301.13	Cyclothymic Disorder	Mood Disorders
297.1	Delusional Disorder	Psychotic Disorders
301.6	Dependent Personality Disorder	Personality Disorders
300.6	Depersonalization Disorder	Dissociative Disorders
311	Depressive Disorder NOS	Mood Disorders
300.12	Dissociative Amnesia	Dissociative Disorders
300.15	Dissociative Disorder NOS	Dissociative Disorders
300.13	Dissociative Fugue	Dissociative Disorders
300.14	Dissociative Identity Disorder	Dissociative Disorders
302.76	Dyspareunia	Sexual Disorders, Sexual Dysfunctions
307.47	Dyssomnia NOS	Sleep Disorders, Dyssomnias
307.44	Dyssomnia Related to (Another Disorder)	Sleep Disorders
300.4	Dysthymic Disorder	Mood Disorders
307.5	Eating Disorder NOS	Eating Disorders
302.4	Exhibitionism	Sexual Disorders, Paraphilias
625	Female Dyspareunia Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
625.8	Female Hypoactive Sexual Desire Disorder Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
302.73	Female Orgasmic Disorder	Sexual Disorders, Sexual Dysfunctions
302.72	Female Sexual Arousal Disorder	Sexual Disorders, Sexual Dysfunctions
302.81	Fetishism	Sexual Disorders, Paraphilias
302.89	Frotteurism	Sexual Disorders, Paraphilias

Code	Disorder	Category
302.85	Gender Identity Disorder in Adolescents or Adults	Sexual Disorders, Gender Identity Disorder
302.6	Gender Identity Disorder in Children	Sexual Disorders, Gender Identity Disorder
302.6	Gender Identity Disorder NOS	Sexual Disorders, Gender Identity Disorder
300.02	Generalized Anxiety Disorder	Anxiety Disorders
301.50	Histrionic Personality Disorder	Personality Disorders
302.71	Hypoactive Sexual Desire Disorder	Sexual Disorders, Sexual Dysfunctions
300.7	Hypochondriasis	Somatoform Disorders
312.3	Impulse -Control Disorder NOS	Impulse-Control Disorders
307.42	Insomnia Related to (Another Disorder)	Sleep Disorders
312.34	Intermittent Explosive Disorder	Impulse-Control Disorders
312.32	Kleptomania	Impulse-Control Disorders
296.36	Major Depressive Disorder, Recurrent, In Full Remission	Mood Disorders
296.35	Major Depressive Disorder, Recurrent, In Partial Remission	Mood Disorders
296.31	Major Depressive Disorder, Recurrent, Mild	Mood Disorders
296.32	Major Depressive Disorder, Recurrent, Moderate	Mood Disorders
296.34	Major Depressive Disorder, Recurrent, Severe With Psychotic Features	Mood Disorders
296.33	Major Depressive Disorder, Recurrent, Severe Without Psychotic Features	Mood Disorders
296.30	Major Depressive Disorder, Recurrent, Unspecified	Mood Disorders
296.26	Major Depressive Disorder, Single Episode, In Full Remission	Mood Disorders
296.25	Major Depressive Disorder, Single Episode, In Partial Remission	Mood Disorders
296.21	Major Depressive Disorder, Single Episode, Mild	Mood Disorders
296.22	Major Depressive Disorder, Single Episode, Moderate	Mood Disorders
296.24	Major Depressive Disorder, Single Episode, Severe With Psychotic Features	Mood Disorders
296.23	Major Depressive Disorder, Single	Mood Disorders

Code	Disorder	Category
	Episode, Severe Without Psychotic Features	
296.20	Major Depressive Disorder, Single Episode, Unspecified	Mood Disorders
608.89	Male Dyspareunia Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
302.72	Male Erectile Disorder	Sexual Disorders, Sexual Dysfunctions
607.84	Male Erectile Disorder Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
608.89	Male Hypoactive Sexual Desire Disorder Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
302.74	Male Orgasmic Disorder	Sexual Disorders, Sexual Dysfunctions
293.83	Mood Disorder Due to Medical Condition	Mood Disorders
301.81	Narcissistic Personality Disorder	Personality Disorders
347	Narcolepsy	Sleep Disorders, Dyssomnias
307.47	Nightmare Disorder	Sleep Disorders, Parasomnias
300.3	Obsessive Compulsive Disorder	Anxiety Disorders
301.4	Obsessive-Compulsive Personality Disorder	Personality Disorders
625.8	Other Female Sexual Dysfunction Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
608.89	Other Male Sexual Dysfunction Due to Medical Condition	Sexual Disorders, Sexual Dysfunctions
307.89	Pain Disorder Associated with both Psychological Factors and Medical Conditions	Somatoform Disorders
307.8	Pain Disorder Associated with Psychological Features	Somatoform Disorders
300.21	Panic Disorder with Agoraphobia	Anxiety Disorders
300.01	Panic Disorder without Agoraphobia	Anxiety Disorders
301.0	Paranoid Personality Disorder	Personality Disorders
302.9	Paraphilia, NOS	Sexual Disorders, Paraphilias
307.47	Parasomnia NOS	Sleep Disorders, Parasomnias
312.31	Pathological Gambling	Impulse-Control Disorders
302.2	Pedophilia	Sexual Disorders, Paraphilias
301.9	Personality Disorder NOS	Personality Disorders
309.81	Posttraumatic Stress Disorder	Anxiety Disorders

Code	Disorder	Category
302.75	Premature Ejaculation	Sexual Disorders, Sexual Dysfunctions
307.44	Primary Hypersomnia	Sleep Disorders, Dyssomnias
307.42	Primary Insomnia	Sleep Disorders, Dyssomnias
293.81	Psychotic Disorder Due to Medical Condition, with Delusions	Psychotic Disorders
293.82	Psychotic Disorder Due to Medical Condition, with Hallucinations	Psychotic Disorders
298.9	Psychotic Disorder, NOS	Psychotic Disorders
312.33	Pyromania	Impulse-Control Disorders
295.70	Schizoaffective Disorder	Psychotic Disorders
301.20	Schizoid Personality Disorder	Personality Disorders
295.20	Schizophrenia, Catatonic Type	Psychotic Disorders
295.10	Schizophrenia, Disorganized Type	Psychotic Disorders
295.30	Schizophrenia, Paranoid Type	Psychotic Disorders
295.60	Schizophrenia, Residual Type	Psychotic Disorders
295.90	Schizophrenia, Undifferentiated Type	Psychotic Disorders
295.40	Schizophreniform Disorder	Psychotic Disorders
301.22	Schizotypal Personality Disorder	Personality Disorders
302.79	Sexual Aversion Disorder	Sexual Disorders, Sexual Dysfunctions
302.9	Sexual Disorder NOS	Sexual Disorders
302.7	Sexual Dysfunction NOS	Sexual Disorders, Sexual Dysfunctions
302.83	Sexual Masochism	Sexual Disorders, Paraphilias
302.84	Sexual Sadism	Sexual Disorders, Paraphilias
297.3	Shared Psychotic Disorder	Psychotic Disorders
780.54	Sleep Disorder Due to A Medical Condition, Hypersomnia Type	Sleep Disorders
780.52	Sleep Disorder Due to A Medical Condition, Insomnia Type	Sleep Disorders
780.59	Sleep Disorder Due to A Medical Condition, Mixed Type	Sleep Disorders
780.59	Sleep Disorder Due to A Medical Condition, Parasomnia Type	Sleep Disorders
307.46	Sleep Terror Disorder	Sleep Disorders, Parasomnias
307.46	Sleepwalking Disorder	Sleep Disorders, Parasomnias

Code	Disorder	Category
300.23	Social Phobia	Anxiety Disorders
300.81	Somatization Disorder	Somatoform Disorders
300.81	Somatoform Disorder NOS	Somatoform Disorders
300.29	Specific Phobia	Anxiety Disorders
302.3	Transvestic Fetishism	Sexual Disorders, Paraphilias
312.39	Trichotillomania	Impulse-Control Disorders
300.81	Undifferentiated Somatoform Disorder	Somatoform Disorders
306.51	Vaginismus	Sexual Disorders, Sexual Dysfunctions
302.82	Voyeurism	Sexual Disorders, Paraphilias

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX C. CALIFORNIA CODE 5150

Article 1. Detention of Mentally Disordered Persons for Evaluation and Treatment

Section 5150.[186]

When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. The facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, the person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

Section 5150.05.

(a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, any person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others, or to himself or herself, or is gravely disabled as a result of the mental disorder.

(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person.

(c) If the probable cause in subdivision (a) is based on the statement of a person other than the one authorized to take the person into custody pursuant to Section 5150, a member of the attending staff, or a professional person, the person making the statement shall be liable in a civil action for intentionally giving any statement that he or she knows to be false.

(d) This section shall not be applied to limit the application of Section 5328.

---

[186] California Legislature, "Welfare and Institutions Code Section 5150," accessed September 29, 2014, http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5150-5155. All material in Appendix C is from this source.

THIS PAGE INTENTIONALLY LEFT BLANK

LIST OF REFERENCES

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder*. 4th ed. Arlington, VA: American Psychiatric Publishing, 2000.

Amore, Mario, Marco Menchetti, Christina Tonti, Fabiano Scarlatti, Eva Lundgren, William Esposito, and Domenico Berardi. "Predictors of Violent Behavior among Acute Psychiatric Patients: Clinical Study." *Psychiatry and Clinical Neurosciences* 62, no. 3 (June 2008): 247–255.

APA Panel of Experts. "Gun Violence: Prediction, Prevention, and Policy." American Psychological Association. 2013. http://www.apa.org/pubs/info/reports/gun-violence-prevention.aspx

Archer, Dale. "Mass Murders are on the Rise: Single Death Homicides are Down While Mass Murders are Up. Why?" *Psychology Today*, July 28, 2012. Accessed March 17, 2014. http://www.psychologytoday.com/blog/reading-between-the-headlines/201207/mass-murders-are-the-rise

Bernstein, Peter L. *Against the Gods: The Remarkable Story of Risk*. New York: Wiley and Sons, 1996.

Bakker, Leon, James O'Malley, and David Riley, *Storm Warning: Statistical Models for Predicting Violence*. New Zealand Department of Corrections. 1998. http://www.corrections.govt.nz/__data/assets/pdf_file/0005/665609/storm.pdf

Biasotti, Michael C. "Management of the Severely Mentally Ill and its Effects on Homeland Security." Master's thesis, Naval Postgraduate School, 2011.

Bittner, Egon. "Police Discretion in Emergency Apprehension of Mentally Ill Persons." *Social Problems* 14, no. 3 (1967): 278–292.

Blair, J. Pete, Martaindale, M. Hunter, and Nichols, Terry. "Active Shooter Events from 2000 to 2012." *FBI Law Enforcement Bulletin*, January 2014. http://leb.fbi.gov/2014/january/active-shooter-events-from-2000-to-2012

Bongar, Bruce, Lisa M. Brown, Larry E. Beutler, James N. Breckenridge, and Philip G. Zimbardo, eds. *Psychology of Terrorism*. New York: Oxford University Press, 2007.

Bonovitz, J. C., and J. S. Bonovitz. "Diversion of the Mentally Ill into the Criminal Justice System: The Police Intervention Perspective." *American Journal of Psychiatry* 138, no. 7 (1981): 973–976.

Borum, Randy, Robert Fien, Bryan Vossekuil, and John Berglund. “Threat Assessment: Defining an Approach for Evaluating Risk of Targeted Violence.” *Behavioral Sciences and the Law* 17, no. 3 (1999): 323–337.

Brennan, Patricia A., Mednick, Sarnoff A., and Hodgins, Sheilagh. “Major Mental Disorders and Criminal Violence in a Danish Birth Cohort.” *Archives of General Psychiatry*, 57, no. 5 (May 2000): 494–500.

Bukowski, Charles. *Ham on Rye*. Santa Rosa: Black Sparrow Press, 1982.

Canter, David, and Rita Zukauskiene. *Psychology and Law: Bridging the Gap*. Burlington, CA: Ashgate Publishing Company, 2008.

Chivers, Tom. “Psychopaths, How Can You Spot One?” *The Telegraph*, April 6, 2014. Accessed June 28, 2014. http://www.telegraph.co.uk/culture/books/10737827/Psychopaths-how-can-you-spot-one.html?fb

Conroy, Mary Alice, and Daniel C. Murrie, Daniel C. *Forensic Assessment of Violence Risk: A Guide for Risk Assessment and Risk Management*. Hoboken, NJ: John Wiley & Sons, Inc., 2007.

Dahl, Erik J. *Intelligence and Surprise Attack: Failure and Success from Pearl Harbor to 9/11 and Beyond.* Washington, DC: Georgetown University Press, 2013.

Dean, Martha Williams, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph P. Morrisey. “Emerging Partnerships between Mental Health and Law Enforcement.” *Psychiatric Services* 50, no. 1 (January, 1999): 99–101. Accessed September 1, 2014. http://www.popcenter.org/problems/mental_illness/PDFs/Deane_etal_1999.pdf

Barrett, Delvin. “Mass Shootings on the Rise, FBI Says.” *The Wall Street Journal*, September 24, 2014. Accessed September 25, 2014. http://www.wsj.com/articles/mass-shootings-on-the-rise-fbi-says-1411574475

Dolan, Mairead, and Michael Doyle. “Violence risk prediction: Clinical and actuarial measures and the role of the Psychopathy Checklist.” *British Journal of Psychiatry* 177 (2000): 303–311.

DuPont, Randolph, Sam Cochran, and Sarah Pillsbury. “Crisis Intervention Team Core Elements.” Memphis, TN: University of Memphis School of Urban Affairs and Public Policy, 2007. http://cit.memphis.edu/information_files/CIT_Brief_Overview_Presentation_Slides.pdf

Elbogen, Eric B., and Sally C. Johnson. “The Intricate Link between Violence and Mental Disorder.” *Archives of General Psychology* 66, no. 2 (2009): 152–161.

Fein, Robert A,. and Bryan Vossekuil. *Protective Intelligence & Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials*. Washington, DC: U.S. Department of Justice, 1998.

Fields, Gary. "Lives of Mentally Ill, Police Collide: Law-enforcement Professionals and Mental-health Advocates Believe They Are Seeing an Increase in Fatal Encounters between Police and the Mentally Ill. *The Wall Street Journal*, October 22, 2013. Accessed June 18, 2014. http://online.wsj.com/news/articles/SB10001424052702304561004579135623495179250

Flores, Adolfo, Richard Winter, and Kate Mather. "Deputies Didn't Know Elliot Rodger Had Firearms before Deadly Rampage." *Los Angeles Times*, May 30, 2014. Accessed June 12, 2014. http://www.latimes.com/local/lanow/la-me-ln-elliot-rodger-guns-sheriff20140530-story.html

Fox, James Alan, and Jack Levin. *Extreme Killing: Understanding Serial and Mass Murder.* Los Angeles: Sage Publications, Ltd, 2012.

Gaffney, James P. "Can Police Prevent an Active Shooting Incident?" *Law Enforcement Today*, April 19, 2014. Accessed May 6, 2014. http://www.lawenforcementtoday.com/2014/04/19/can-police-prevent-an-active-shooting-incident/

Gardner, Sheila. "Man Accused of Threatening Neighbors." *The Record Courier*, March 29, 2013.

Glionna, John M., and Rebecca Trounson. "Man Accused of Bombing Plot Hated Everyone." *Los Angeles Times*, February 1, 2001. Accessed June 21, 2014. http://articles.latimes.com/2001/feb/01/news/mn-19794

Gold, Jenny. "The Mentally Ill Mostly Go to Jail, Not Psych Hospitals: American Jails House 10 Times More Mentally Ill People Than State Hospitals." *Kaiser Health News*, April 9, 2014. Accessed April 11, 2014. http://www.governing.com/news/headlines/the-mentally-ill-mostly-go-to-jail-not-.html

Guara, Maria Alicia, Matthew B. Stannard, and Stacy Fin, "De Anza College Blood Bath Foiled—Photo Clerk Calls Cops." SF Gate. January 31, 2001. Accessed June 28, 2014. http://www.sfgate.com/bayarea/article/De-Anza-College-Bloodbath-Foiled-Photo-Clerk-2957361.php

Hails, Judy, and Randy Borum. "Police Training and Specialized Approaches to Respond to People with Mental Illnesses." *Crime and Delinquency* 49, no. 52 (2003): 52–61.

Harris, Grant T., Marnie E. Rice, Vernon L. Quinsey, Martin L. Lalumiere, Douglas Boer, and Carol Lang, "A Multisite Comparison of Actuarial Risk Instruments for Sex Offenders." *Psychological Assessment* 15, no. 3 (2003): 413–423.

Hubert, Cynthia. "Police Say Violent Encounters with Mentally Ill People on the Rise." *Sacramento Bee*. August 25, 2014. Accessed September 1, 2014. http://www.sacbee.com/2014/08/25/6651255/police-say-violent-encounters.html

Ionides, Alex. "Deguzman Trial Delayed." *LaVoz Weekly*, November 13, 2001. Accessed August 26, 2014. http://lavozdeanza.com/uncategorized/2001/11/13/deguzman-trial-delayed/

Ionides, Alex. "This Boy's Plan." Metroactive. January 31, 2002. Accessed August 26, 2014. http://www.metroactive.com/papers/metro/01.31.02/cover/deguzman-0205.html

Jines, Johnny K. "Crisis Intervention Teams: Responding to Mental Illness Crisis Calls." *FBI Law Enforcement Bulletin*, January 2013.

Johnson, Kevin. "Memphis Program Offers Example for Police and Mentally Ill." *USA Today*, October 2, 2013. http://www.usatoday.com/story/news/nation/2013/10/02/police-navy-yard-mental-illness-alexis-shooting/2910763/

Johnson, Kevin. "Mental Illness Cases Swamp Criminal Justice System." *USA Today*, July 21, 2014. Accessed September 1, 2014. http://www.usatoday.com/longform/news/nation/2014/07/21/mental-illness-law-enforcement-cost-of-not-caring/9951239/

Kaplan, Stanley, and Garrick, B. John. "On the Quantitative Definition of Risk." *Risk Analysis* 1, no. 1 (1981): 11–27.

Kelly, Timothy A. *A Policy Maker's Guide to Mental Illness*. The Heritage Foundation. 2002. Accessed June 23, 2014. http://www.heritage.org/Research/HealthCare/BG1522ES.cfm

Kessler, Ronald, Wai Tat Chiu, Olga Demler, and Ellen E. Walters. "Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication." *Archives of General Psychiatry* 62, no. 6 (2005): 617–627.

Lamb, H. Richard, Linda E. Weinberger, and Walter J. DeCuir, Jr. "The Police and Mental Health." *Psychiatric Services* 53, no.10 (2002): 1266–1271. Accessed August 17, 2014, http://psychiatryonline.org/doi/abs/10.1176/appi.ps.53.10.1266

Langman, Peter. “Elliot Rodger: A Psychotic Psychopath?” *Psychology Today*, May 28, 2014. Accessed January 8, 2015. http://www.psychologytoday.com/blog/keeping-kids-safe/201405/elliot-rodger-psychotic-psychopath

“Lunatics at Large and the Public Press.” *Journal of Mental Science* 44 (January 1898): 110–112. http://bjp.rcpsych.org/content/44/184/110

Lurigio, Arthur J., and Andrew J. Harris. “Mental Illness, Violence, and Risk Assessment: An Evidence-Based Review.” *Victims and Offenders* 4 (2009): 341–347.

Mail Online. “Virgin Killer’s Parents Read His Hate-filled Manifesto then Called the Police and Rushed to Stop Him When They Heard of Murder Spree on Their Car Radio.” May 25, 2014. Accessed August 25, 2014. http://www.dailymail.co.uk/news/article-2639177/Parents-shooter-read-manifesto-driving-stop-son-heard-massacre-radio-revealed-investigators-search-moms-house.html

Meloy, J. Reid, and Jens Hoffmann. *International Handbook of Threat Assessment*. New York: Oxford University Press, 2014.

Miller, Anna. “Threat Assessment in Action.” *Monitor on Psychology* 45, no. (2014): 37–38.

Molina, Josh. “Elliot Rodger and a Call for Help.” Mission and State. June 4, 2014. Accessed August 25, 2014. http://www.missionandstate.org/homepage-layout/featured-story-center/elliot-rodger-call-help/

Monahan, John. *Clinical Prediction of Violent Behavior*. New York, NY: Jason Aronson, Inc., 1977.

Monahan, John, Henry J. Steadman, Eric Silver, Paul S. Appelbaum, Pamela Clark Robbins, Edward P. Mulvey, Loren H. Roth, Thomas Grisso, and Steven Banks. *Rethinking Risk Assessment: The MacArthur Study of Mental Disorder and Violence.* New York: Oxford University Press, 2001.

Morabito, Melissa Schaefer. “Horizons of Context: Understanding the Police Decision to Arrest People with Mental Illness.” *Psychiatric Services* 58, no. 12 (2007): 1582–1587.

Morton, Robert J., ed. “Serial Murder: Multi-disciplinary Perspectives for Investigators,” FBI Behavioral Analysis Unit 2. 2005. Accessed March 12, 2013. http://www.fbi.gov/stats-services/publications/serial-murder

Norko, Michael A., and Baranoski, Madelon V. “The Prediction of Violence; Detection of Dangerousness.” *Brief Treatment and Crisis Intervention* 8, no. 1 (February 2008): 73–91.

Orgloff, James R. P., and Michael Daffern. “The Dynamic Appraisal of Situational Aggression: An Instrument to Assess Risk for Imminent Aggression in Psychiatric Inpatients.” *Behavioral Sciences and the Law* 24, (2006): 799–813. DOI: 10.1002/bsl

Otto, Randy. “Assessing and Managing Violence Risk in Outpatient Settings.” *Journal of Clinical Psychology* 56, no. 10 (2000): 1239–1262.

Parry, John, “Involuntary Civil Commitment in the 90’s: A Constitutional Perspective.” *Mental and Physical Disability Law Reporter* 18, no. 3 (1994): 320–336.

Patch, Peter C., and Arrigo, Bruce A. “Police Officer Attitudes and Use of Discretion in Situations Involving the Mentally Ill.” *International Journal of Law and Psychiatry* 22, no. 1 (1999): 23–35.

Pauly, Megan. “How Police Officers Are (or Aren’t) Trained in Mental Health.” *The Atlantic*. October 11, 2013. Accessed September 1, 2014. http://www.theatlantic.com/health/archive/2013/10/how-police-officers-are-or-aren-t-trained-in-mental-health/280485/

Petherick, Wayne, *Applied Crime Analysis: A Social Science Approach to Understanding Crime, Criminals, and Victims*. Waltham, MA: Anderson Publishing, 2015.

Poincare, Henri. *The Foundations of Science: Science and Hypothesis: The Value of Science, Science and Method*. New York: The Science Press, 1913.

RachBeisel, Jill, Jack Scott, and Lisa Dixon. “Co-Occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research.” *Psychiatric Services* 50, no. 11 (1999): 1427–1434. Accessed August 25, 2014. http://journals.psychiatryonline.org/article.aspx?articleid=83559#Conclusions

Reich, Robert. “Care of the Chronically Mentally Ill: A National Disgrace.” *American Journal of Psychiatry* 130 (1973): 911–912.

Reisner, Ralph, Christopher Slobogin, and Arti Rai, *Law and the Mental Health System: Civil and Criminal Aspects*. Berkeley, CA: West Group, 2009.

Schmid, David. *Natural Born Celebrities: Serial Killers in American Culture*. Chicago: University of Chicago Press, 2005.

Sheridan, EP, and L. Teplin, “Police-Referred Psychiatric Emergencies: Advantages of Community Treatment.” *Journal of Community Psychology* 9, no. 2 (1981): 140–147.

Silver, Eric. *Mental Illness and Violence: The Importance of Neighborhood Context.* New York: LFB Scholarly Publishing LLC, 2001.

Silver, Eric. “Understanding the Relationship between Mental Disorder and Violence: The Need for a Criminological Perspective.” *Law and Human Behavior* 30, no. 6 (2006): 685–706.

Simons, Andre. *FBI Behavioral Analysis Unit*. Quantico, VA: National Center for the Analysis of Violent Crime, 2012. Accessed April 5, 2014. http://www.dbhds.virginia.gov/documents/130124Simons.pdf

Skeem, Jennifer L., Devon L. L. Polaschek, Christopher J. Patrick, and Scott Lillienfeld. “Psychopathic Personality: Bridging the Gap between Scientific Evidence and Public Policy.” *Psychological Science in the Public Interest* 12, no. 3 (2011): 95–162.

Steadman, Henry J., Deane, Martha Williams, Borum, Randy, and Morrisey, Joseph P. “Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies.” *Psychiatric Services* 51, no. 5 (2000): 645–649.

Stettin, Brian, Jeffrey Geller, Kristina Ragosta, Kathryn Cohen, and Jennay Ghowrwal. “Mental Health Commitment Laws: A Survey of the States.” Treatment Advocacy Center. February 2014. Accessed January 26, 2015. http://www.tacreports.org/storage/documents/2014-state-survey-abridged.pdf

Swanson, Jeffrey W. “Explaining Rare Acts of Violence: The Limits of Evidence from Population Research.” *Psychiatric Services* 62, no. 11 (2011): 1369–1371.

Szabo, Liz. “Psychiatric Bed Disappear Despite Growing Demand.” *USA Today*, May 12, 2014. Accessed June 17, 2014. http://www.usatoday.com/story/news/nation/2014/05/12/disappearing-hospital-beds/9003677/

Szenberg, Michael. *Eminent Economists: Their Life Philosophies.* New York: Cambridge University Press, 1992.

Teplin, Linda A. “Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill.” *American Psychologist* 39, no. 7 (1984): 794–803.

Teplin, Linda A. “Keeping the Peace: Police Discretion and Mentally Ill Persons.” *National Institute of Justice Journal* 244 (July 2000): 8–15.

Torrey, E. Fuller. *The Insanity Offense: How America’s Failure to Treat the Seriously Mentally Ill Endangers Its Citizens.* New York: W.W. Norton and Co., Inc., 2008.

Tucker, Abigail S., Vincent B. Van Hasselt, and Scott A. Russell. “Law Enforcement Response to the Mentally Ill: An Evaluative Review.” *Brief Treatment and Crisis Intervention* 8, no. 3 (2008): 236–250. DOI:10.1093/brief-treatment/mhn014.

Upton, Jodi, Overberg, Paul, and Meghan Hoyer. “Behind the Bloodshed: The Untold Story of America’s Mass Killings. *USA Today*, December 4, 2013. Accessed December 6, 2013. http://usatoday30.usatoday.com/news/nation/mass-killings/index.html#explore

U.S. Department of the Navy. *Report of the Investigation into the Fatal Shooting Incident at the Washington Navy Yard on September 16, 2013 and Associated Security, Personnel, and Contracting Policies and Practices.* November 8, 2013. http://www.defense.gov/pubs/Navy-Investigation-into-the-WNY-Shooting_final-report.pdf

Van den Brink, Rob, Jan Broer, Alfons J. Tholen, Wim H. Winthorst, Ellen Visser, and Durk Wiersma. “Role of the Police in Linking Individuals Experiencing Mental Health Crises with Mental Health Services.” *BMC Psychiatry* 12, no. 171 (2012). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3511214/

Varandani, Suman. “California Police Knew of Elliot Rodger’s Disturbing Videos Days before His Shooting Spree but Did Not Watch Them.” *International Business Times*, May 30, 2014. Accessed August 25, 2014. http://www.ibtimes.com/california-police-knew-elliot-rodgers-disturbing-videos-days-his-shooting-spree-did-not-1592327

Vargas, Theresa, Steve Hendrix, and Marc Fisher. “Aaron Alexis, 34, is Dead Gunman in Navy Yard Shooting, Authorities Say.” *The Washington Post*. September 17, 2013. Accessed August 12, 2014. http://www.washingtonpost.com/politics/aaron-alexis-34-is-dead-gunman-in-navy-yard-shooting-authorities-say/2013/09/16/dcf431ce-1f07-11e3-8459-657e0c72fec8_story.html

Vickers, Betsy. *Memphis, Tennessee Police Department’s Crisis Intervention Team, Practitioners Perspectives*. Washington, DC: U.S. Department of Justice, 2000. Accessed August 26, 2014. https://www.ncjrs.gov/pdffiles1/bja/182501.pdf

Vossekuil, Bryan, Robert A. Fein, Marisa Reddy, Randy Borum, and William Modzeleski. *The Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States*. Washington, DC: The United States Secret Service and the United States Department of Education, 2002.

Webster, Daniel W., and Jon S. Vernick, *Reducing Gun Violence in America: Informing Public Policy with Evidence and Analysis.* Baltimore: Johns Hopkins University Press, 2013.

Wirtz, James J. “The American Approach to Intelligence Studies.” In *Handbook of Intelligence Studies*, edited by Loch K. Johnson. London: Routlege, 2007.

Wood, Jennifer, Jeffrey Swanson, Scott Burris, and Allison Gilbert. *Police Interventions with Persons Affected by Mental Illness*. Piscataway, NJ: Rutgers Center for Behavioral Health Services & Criminal Justice Research, 2011.

Woody, Michael S. "Dutiful Minds: Dealing with Mental Illness." CIT International. January 6, 2003. Accessed September 1, 2014. http://www.citinternational.org/training-overview/129-dutiful-minds-dealing-with-mental-illness.html

THIS PAGE INTENTIONALLY LEFT BLANK

INITIAL DISTRIBUTION LIST

1. Defense Technical Information Center
   Ft. Belvoir, Virginia

2. Dudley Knox Library
   Naval Postgraduate School
   Monterey, California